Thursday, 19 April 2012

(10.00 am)

(Delay in proceedings)

(10.32 am)

THE CHAIRMAN: I am sorry, ladies and gentlemen, for the delay. We'll try and catch up some time and we will not break this morning until some time after 11.30, maybe 11.45 or so.

MR UBEROI: I think the delay was partly at our request and we thank you for the time.

THE CHAIRMAN: You're excused anyway. There was a problem at our end, but everything is back on track. Thank you.

Ms Anyadike-Danes.

MS ANYADIKE-DANES: Thank you very much, Mr Chairman.

Good morning, everybody. I wonder, just before I ask if Dr Taylor could come to the witness stand, if I may make a couple of points.

Firstly, when Professor Savage was in the witness box yesterday, I had put to him a letter from management executive, the office of the chief executive, dated 6 October 1995. The purpose of it really was to enclose a guide to consent, and I had put that to him and he had said he hadn't seen it. He wondered whether it would have got to him given the date of it. What I wasn't able to do is give anyone a reference for it because it

hadn't, at that stage, been given one. I can now. The letter itself starts at 305-002-003. Then the guide itself starts at 305-002-005. So that should be up with all the other documents for the inquiry.

The other thing I wanted to say is that Professor Savage had very kindly made available his professional CV, which you all had copies of. It's going to be on the website with a reference number and, obviously, redacted in accordance with the protocol of the inquiry.

I think, whilst he was in the witness box, he actually made two corrections: he made a correction to his initial title, which should have been emeritus professor; and he also made a correction to a point in time when he had taken up an appointment, which should, I think, have been 1999. You will see those corrections are made on his CV. They are our corrections, but at his direction, because he reflects what he said in the witness box.

Dr Taylor also has a CV. I think you also should have received a copy of it. That too will be ascribed a reference number and he has also permitted that, suitably redacted, to be on the website in the usual way with all the other inquiry documents.

So that having been said, I wonder if Dr Taylor

could come to the witness stand.

DR ROBERT TAYLOR (called)

Questions from MS ANYADIKE-DANES

MS ANYADIKE-DANES: Good morning, Dr Taylor. Do you have there your CV?

A. No.

Q. There we are. (Handed).

I wonder if we might go to the second page of it, which deals with your education and qualifications, and also your membership of societies and appointments. I think we see that, in 1988, you held a paediatric critical care fellowship in Toronto, Canada. You have referred previously in some of your witness statements to having some knowledge of Des Bohn in the Toronto Hospital For Sick Children. Is that associated with that fellowship?

A. Yes.

Q. And then you go on with --

THE CHAIRMAN: Dr Bohn being one of the peer reviewers to the inquiry.

MS ANYADIKE-DANES: He is. Dr Des Bohn is a peer reviewer for the inquiry.

A. Yes.

Q. Then in that same year, paediatric anaesthesia fellowship, also in Toronto, Canada, going on

to June 1989; is that correct?

A. Sorry, that seems to be an error. 1988 to 1989 was the paediatric critical care fellowship, and 1989 to 1990 was the anaesthesia fellowship.

Q. I see, thank you. Do you mind if we correct that?

A. It's actually corrected on the next page on the list of appointments.

Q. There we are.

A. That's my error. I apologise for that.

Q. Not to worry. Then if we look at your appointments, you're a senior house officer in anaesthesia in August 1983. And then you come to the Royal Hospitals in July 1985; is that right?

A. That's correct.

Q. And then you proceed through to 1990, when you go again to the Hospital For Sick Children. Can you explain what that was? It was for further experience?

A. I spent two years in Toronto: one year doing paediatric --

Q. That started in 1989? And then you --

A. -- intensive care. Sorry, it started in July 1988 and one year in the PICU, the paediatric intensive care unit. And that was followed consecutively, without a break, by a second year in the paediatric anaesthesia fellowship at the same institution.

Q. Then you come back in 1990, do you, to Belfast?
A. I do.
Q. And then, in 1990, when you come back, you're a senior registrar and then, by 1991, you are a consultant; is that right?
A. That's correct.
Q. Some might call that a rather speedy rise.
A. Um ...
Q. You don't have to answer that. If we then go to your publications. With the exception of, on page 7, item number 36, which has you with Jenkins and McCarthy on "The prevention of hyponatraemia in children receiving fluid therapy". That's published in the Ulster Medical Journal in 2003. And then, item 39, you are with Jenkins in "The prevention of hyponatraemia". Is that first published in January 1989? Surely not.
THE CHAIRMAN: Is it not 2004?
MS ANYADIKE-DANES: Is that the volume number 89, then?
A. I believe it is.
Q. Yes, so that publication was in 2004?
A. Yes, it says 2004 --
Q. That's what I was checking, then I saw "January 1989". With the exception of those two publications, have you published anything that relates to the matters in issue now in Adam's case?

A. I don't believe so.
Q. Then if we go over the page to page 9, where you deal with your research grants and the sponsor of research fellows. We see first there is Dr Montague, who's an applicant for a research fellowship award. Is that the Dr Montague that's involved in this case?
A. Yes.
Q. Is there anyone else that you have sponsored by way of research fellowship who's involved in this case?
A. No.
Q. Thank you. Then you have your teaching experience. You have taught at both undergraduate and postgraduate level; is that right?
A. That's right.
Q. And you have also had some management experience at the trust. One finds that at page 11. Can you say a little bit about what that education sub-committee is for? That seems to be a post that you held prior to and during the time of Adam's case in 1995. What is that?
THE CHAIRMAN: This is at the top of page 11, heading number 1?
MS ANYADIKE-DANES: Yes, that's correct.
Do you see it there?
A. Yes, indeed.
Q. What is that?

A. ATICS is an abbreviation for "Anaesthetic, Theatres and Intensive Care Directorate". So that is the department or the directorate for which I was a member of the Royal Group of Hospitals Trust, as it was in those days. I was a member of the education subcommittee for, basically -- we reviewed the competencies and practice of the junior anaesthetists and their rotations through the various areas of the Royal Hospital.

Q. When you say you "review" them, with a view to what?

A. We ensured that SHOs and registrars, as they were in those days, rotated through the various areas of the Royal Hospital -- for instance the paediatrics, cardiac surgery, ENT surgery. The Mater Hospital was included in the rotation of the trainees, so it was usual for them to spend three-month periods attached to the various theatre areas of the Royal Hospitals.

Q. And if they were experiencing any difficulties -- I mean from a medical point of view -- in terms of keeping up or understanding, does your committee have any say as to whether they're achieving the appropriate level of expertise?

A. In those days, it was less objective than it is now. Every trainee in anaesthesia has a logbook and a competency tick-box form to go through, and consultants in the various areas will tick them off with the various

competencies and their abilities in each area. Then they undertake a mentoring or a consultant will review that at each stage. In those days, that was less well-organised, but it did occur with every trainee.

Q. And did you have trainees yourself in those days?

A. Yes, I would have been the lead consultant, if you like, in the Royal Belfast Hospital For Sick Children, responsible for the trainees who were attached to our area.

Q. And so if there were concerns about their competencies, you're the lead consultant on that committee, that's something that would come to you?

A. Yes. I would feed back to the chairperson of that committee how each trainee had performed during the three-month attachment.

Q. Thank you. Can I ask you about another committee that -- well, two others actually, that you were on round about the time of Adam's admission. You were on the committee, still under that section, the audit subcommittee of ATICS. What does that mean exactly? Sorry, what does that do?

A. Clinical audit came in really around that time, 1992, when I was co-opted or asked to sit on that committee. A clinical audit -- and I think it was initially called medical audit -- was coming in as a method of doctors

undertaking reviews of their outcomes with certain patients, with certain treatments.

Q. That involved things -- I think we've heard reference to morbidity meetings. Is that the sort of think that you are talking about?

A. Yes.

Q. And if you were on that subcommittee, that audit subcommittee, what did that mean in terms of clinical audit?

A. That meant sitting with the other members of the subcommittee from the different theatre areas and ensuring that audit projects were conducted in the areas that -- there was responsibility very often between consultants and a trainee, who undertook a project often to look at outcomes or some form of improvements in patient care.

Q. And if there were going to be morbidity and mortality meetings or reviews, because you were on that committee, on that audit committee, would that mean you would know about them?

A. The members of each area weren't responsible for organising the mortality meetings. It would be the chairman of the audit committee who would organise the audit meetings and bring together the clinical cases that were to be discussed.

Q. No, sorry. I didn't ask it in a very clear way. What I mean is: because you're on that committee, does that mean you would know of them, that a morbidity and mortality meeting was happening?

A. Yes, I would attend the audit meetings on the audit half-days .

Q. Thank you. That's what I meant. I didn't put it very clearly. The other one I wanted to ask you about was under, 2, "National work". You were a member of the working party on neonatal and paediatric transport in 1995. What was that committee about or what did it do?

A. I have very little recollection of that now. It was the SAC for paediatrics, so it was a Speciality Advisory Committee that was set up to advise on certain areas and report. It would have had terms of reference to report, I believe, to the Chief Medical Officer or a person delegated to the Chief Medical Officer.

Q. I was just struck by the word "transport".

A. Transport is the inter-hospital movement of sick patients from a hospital within the province to another hospital within the province.

Q. That's what I wondered. Is it looking at the arrangements for that?

A. Yes, it was looking to make sure that patients were treated satisfactorily prior to their transfer -- often

to the paediatric and neonatal intensive care units -- and that systems were put in place to make sure that -- I believe actually, that committee was looking at a project to see if there could be a centralised service where doctors from the paediatric intensive care would go out and collect and stabilise children and neonates and bring them back to the hospital.

Q. It would involve how you efficiently transported the relevant notes and records and all that sort of thing. I presume you're talking about these children coming from a hospital within the province to the Children's Hospital in Belfast.

A. Yes.

Q. So would it involve something like that: ensuring how you make sure you have medical notes and records, you know what their medical condition was before they got moved or transferred to the Children's Hospital? You may not know, so I'm only asking if --

A. I don't really understand what you mean by "medical notes". Very often, the medical notes would remain in a hospital -- let's say Altnagelvin Hospital retains their own medical notes, but they would send a transfer letter or transfer form with a summary of their medical condition and their blood tests and their other relevant investigations. It wouldn't necessarily mean that all

the patient notes would be transferred with the patient, if that's what you mean.

Q. No, I didn't mean all the notes, I meant the appropriate notes. I meant, if a child is being transferred from one hospital to another, obviously there has been some crisis or some reason why the child now has to come to Belfast. I was wondering if part of what you were concerned with is to ensure that you had the relevant notes. In fact, you have described what they might be: they might be tests, they might be X-rays, they might be anything, but just to make sure that the child and the relevant part of their medical notes and records and results ends up at the hospital for their efficient and best treatment and care. Is that the sort of thing that you were looking at?

A. It was primarily the movement of the patient --

Q. Yes.

A. -- that we were looking at.

Q. Okay.

THE CHAIRMAN: Do I understand from what you've said that, apart from the movement of the patient, the good practice would be that when a patient is brought from Altnagelvin, or wherever, to the Children's Hospital, that if it's not the full notes and records, there's at least some notes and records and a minimum a summary of

what exactly is happening with the child?

A. Absolutely correct.

THE CHAIRMAN: And that pre-dated 1995?

A. That occurred in 1995, I believe.

THE CHAIRMAN: Right. And from then on, that was -- I know it's hard to put dates on these things.

A. I think the working party only sat on [sic] that particular year.

THE CHAIRMAN: When this working party, as Ms Anyadike-Danes was asking you about -- it was primarily focused on the children who were being moved?

A. Yes.

THE CHAIRMAN: Was it already established practice that appropriate notes and records, as she described it, would move with the child? Was that already the practice?

A. Yes, I think when any patient moves between a hospital, there's an understanding that the relevant notes, records, investigations, would move with the child.

THE CHAIRMAN: Okay, thank you.

MS ANYADIKE-DANES: Thank you very much indeed.

Then if we go to the final page of your CV, which is a carrying on from something that's called "audit activity". If you see item 5 on there, you have "paediatric intensive care occupancy", which is

something that you have worked on from 1989 to 1994. And then you've got number 10, "audit of paediatric intensive care deaths". And that was submitted in February 1996.

If we just focus on the item number 10 for the moment, since it's an audit, and you submit it in February 1996, do you know -- and if you don't, say so and you can see if you can help us find where the information is -- what period that audit related to in number 10?

A. I don't remember the period it was related to.

Q. I understand. Would you be in a position to try and help us locate where that work is?

A. It would have been submitted to the Medical Audit Department, which I believe is now the Clinical Risk and Governance Department within the Royal.

Q. Thank you very much indeed.

A. Or the Belfast Health and Social Care Trust.

Q. Thank you. In auditing it, were you doing any analysis on the data or just compiling the data?

A. I can't remember too much about the audit at the moment.

Q. That's all right.

A. Just that -- you've caught me on the hop, I'm afraid. I apologise.

THE CHAIRMAN: I think to put it bluntly, would that have

included Adam's death?

A. I'm afraid you've caught me on the hop. I would have to speculate and I'm not prepared to do that.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: We'll try and see if we can get the document in the way that you suggest. Thank you very much.

I wonder if I can pull up your fifth witness statement, which is WS-008/5. Let's go to page 2. There we are.

Dr Taylor, you received a request, didn't you, from the inquiry to assist us in making comparisons with the different clinicians, and, for that matter, inquiry experts' figures by completing a table that we provided you. That table was Adam's perioperative fluid balance and the purpose of that was to try and see if we can get everybody to set out their assumptions and their figures and then to be able to make comparisons.

This witness statement of yours not only provides the basic information that's going to go on the table, but also provides the completed table; isn't that right?

A. Yes.

Q. Thank you. So if we just go through it quickly, you give the information for the fluid balance table on this page 2, where we are, and then we'll go quickly and look

at your table that you complete for us.

The first question, under 1(a), is what you considered Adam's daily fluid intake to have been prior to his admission. You give that as 2,100 ml. Where do you get that from?

A. I believe that came from the fact he got 1,500 ml of PEG feeds overnight and a further 300 during the lunchtime period, late morning, I believe. And another 300 ml towards late afternoon, early evening. So that would have -- to my knowledge -- have added up to 2,100 ml of input during the day.

Q. When you're asked what you consider his average daily fluid output to be. You have him absolutely balanced: input of 2100, output of 2100.

A. Well, I think --

Q. On average.

A. I think that has to go without -- yes.

Q. He did have periods of dehydration, but you are assuming that that was his average state, that he excreted as much as was put in him, effectively?

A. I think that would be --

Q. Thank you.

A. -- normal.

Q. Then if we look at the urine output, your figure is 1,875 ml; isn't that right?

A. Yes.
Q. And then you have that figure and produced from it, just simple arithmetic, an hourly volume of 78 ml. Where did you get the 1,875 ml figure from?
A. Well, I estimated his insensible losses to be 300 ml per square metre per day and in his notes before his operation, his body surface area was, I believe, calculated by Dr Savage to be -- now Professor Savage -- to be 0.75. So I estimated therefore -- I calculated therefore his insensible losses -- the evaporations through his skin -- to be 225 ml per day. So what I did was I took his daily input and subtracted his insensible losses from his daily input to get 1,875 ml.
Q. Then if we go through, dealing with losses, so you've got his urine output and then you deal with his blood loss. You have his total estimated blood loss to be 1,211 throughout the procedure. You say that you don't have any records of when the blood loss occurred, but you have estimated it in the following way. You go through and do that. So from 8 to 10 you have the view that there was significant blood loss during the surgery and you confirm that through the haemoglobin estimate at 9.30.
And you estimate his blood loss to be 800 ml. How do you calculate it in that way? How do you get from

the haemoglobin at 9.30 to calculating what his estimated blood loss is at 800 ml?

A. I think I need to clarify: it's not a calculation, it's an estimation.

Q. Sorry, you calculate and estimate, I suppose. In any event, yes, estimate.

A. You're quite right when you say there was no timeline of the swab count. The swab counts are weighed, the nurse would often ask me at the start of the operation, did I wish her to weigh the swabs, and on this case, and from major cases, I would always say yes. And the process that involves is for them to weigh a swab dry and then they would put this -- very often they would put the scale at zero with a dry swab on it and from then on every swab of that size that's added to the scales will indicate the wet weight of the swab. From then, they will write up on a whiteboard in theatre each swab as it comes out with its wet weight. So that's the net gain of weight of each swab.

Q. When they write that up on the whiteboard, do they ever -- obviously we'll ask the nurse doing it. From your experience, do they ever put a time to when they're writing that up?

A. That would be an appropriate question to ask the nurse.

Q. No, I know it is, and that's why I prefaced it by the

fact that I would ask that, but I am asking, out of your experience because you have said that very often they would ask you if you wanted them to weigh the swabs and you said, in many cases, you would ask them to do that. So I thought we might carry on with that theme and say: do you ever ask them to, or is it ever done, that they record the time when they're marking up the weight of the swab?

A. Well, from my point of view, the time is not recorded when the swabs are entered on to the whiteboard.

Q. In your experience it's not?

A. Yes, that's correct.

Q. Have you ever asked for it?

A. No.

Q. Is there a reason?

A. I don't understand.

Q. Is there a reason why you haven't asked for it?

A. No. I think it's a procedure that hasn't been traditionally done.

Q. Can we --

A. Therefore I've never asked for it.

Q. Can we pull up a photograph? 300-010-011. This, I am told, when I went on a site visit, is or was Adam's operating theatre. As you know, those rooms are no longer the way that they were at the time of Adam's

operation. But if you see on that wall towards the right, is that the sort of board in which the swabs would be indicated on?

A. From my memory, that is the sort of board that --

Q. Thank you. So you were saying about how the swabs are weighed and there's a gradual accumulation of them as they put them on the scales. What I'm not entirely sure I have understood is how, in all of that, you got an estimate of 800 ml.

A. I did find the table difficult to fill in according to those time periods because they weren't the traditional time periods that I would have been writing down or completing mid-point, mid-operation.

Q. I understand.

A. Losses -- the losses were accumulated towards the end. So I --

Q. I appreciate that.

A. -- I had to make an estimate and that was my best estimate of the time. I don't think there's anything that I can say I calculated. It was an estimate of what I felt his fluid to be at that time.

Q. Then would it be fair to put it in this way, Dr Taylor: you had a view of what the overall blood loss was, you had a view of when, during the surgery, there was likely to be a heavier experience of blood loss than

another, and you sort of apportioned that total amongst the periods, roughly; is that the sort of thing you did, for the purposes of filling in our table?

A. Well, of course you asked me to complete the table some 17 years after the operation had finished.

Q. Yes.

A. So what you asked me to do was to remember what the blood loss was at different phases of the operation, and that is something that was very much an estimate. I can give a -- and unfortunately, I would like to help you here, but I'm afraid after that time period, I can't really give an estimate.

MR UBEROI: In case it assists, I don't know if perhaps the anaesthetic record may assist him in answering the question.

MS ANYADIKE-DANES: It may. We'll try and pull that up in a minute.

MR UBEROI: 058-003-005.

MS ANYADIKE-DANES: Thank you very much indeed. There we are. You can certainly see when you're putting in the HPPF. Does that help?

A. That may help indicate that I would be giving a colloid solution or a solution that would stay in the circulation at a time when blood is being lost from the circulation.

MR McBRIEN: Mr Chairman, could I ask also if perhaps during the course of this line of questioning, one document which might assist with the blood loss and the weights and the timing and could perhaps be interpreted, albeit that it's a nursing document. It's document number 058-007-021.

The timing issue might also be relevant in that Nurse Mathewson, I think it was, stated that she commenced writing it up at a particular point and the timing of her arrival might help correlate the blood loss figures with what Dr Taylor is saying.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: Thank you very much, that's very helpful.

We are actually going to deal with this subject in much greater detail later on. I was simply trying to establish the parameters here. But that is helpful, thank you.

Maybe if I move on a little bit. You have tried, as you say, to estimate this blood loss over the periods that, in fairness to us, we gave you, which are rather artificial periods from your point of view because you weren't recording the loss like that.

Then over the page, you deal with the fluids.

THE CHAIRMAN: Sorry, just before you go over the page,

Mr Uberoi's suggestion was that showing the anaesthetic record might help you, doctor, in estimating how you came to the loss of 800 ml. Does it?

A. Well, I can certainly see the time periods when I gave fluid, but unfortunately it wasn't my practice -- I don't think it was standard practice -- to record intervals at which blood was lost at that interval. So I am unable to more accurately give you the time period according to your chart when certain blood volumes were lost from the circulation, unfortunately.

THE CHAIRMAN: Thank you.

A. I have to emphasise again: it is an estimate, not a calculation.

MS ANYADIKE-DANES: Yes. Then if we go over the page to WS008/5, page 3, there we are. Under (e), what you're being asked to do is state what you consider Adam's fluid losses and fluid intake to have been and what you calculate as either his fluid excess or deficit at each of those stages. And we're going to go over and look at the chart in a minute and we'll see what those stages are.

The ones I'm particularly interested are stages 3 and 4 at the moment. They equate to 7 to 8 o'clock -- that's stage 3 -- and stage 4, 8 to 10 o'clock. At stage 3 you have an estimated excess of 662 ml, and

stage 4, you have an estimated excess of 826 to 910 ml.

We are going to go into all this in more detail, but I'm trying to lay out the position at the outset. Can I ask you this -- and I know they're not your stages, I appreciate that. They are stages that we have put into a chart. But that initial hour and then the two hours after that, which sort of go into about the time of anastomosis, you wouldn't know when you were planning ahead for your fluid balance when the anastomosis would take place. When you write down the excesses and deficits in that way, is that what you expected at the outset to have been the position?

A. I'm afraid ...

Q. Let's go to the table.

A. Can I ask you to rephrase?

Q. The table that you have filled in starts at witness statement 008/5, page 5. Then you can see that the first two periods, which is why I said -- although of course they are important periods, not for what I'm asking you at the moment. The third one starts at 7 to 8 and that's one hour. We can see what was happening there in terms of the losses in the various categories, as we have them.

Then the total, 88. Then we have the actual fluid input of 750, and you'll be able to see that from the

same chart that my learned friend Mr Uberoi helpfully referred us to. And then you've got your estimated fluid excess. Do you see that? That gives you your 662.

Then if we go over the page -- well, it's slightly more than over the page -- to 008/5, page 7, this is losses. There, for 8 to 10, you can see what the total fluid losses were and the estimated fluid excess is there.

So the question that I was asking you is -- and I'm hoping this helps you in a way because this is your data, admittedly in your categories -- for the 7 to 8 period, 8 to 10 period, are these the sort of results that you expected to have when you established your fluid plan before the surgery?

A. Well, I have to say no.

Q. Sorry?

A. I have to say no.

Q. No. Does that mean that the fluid excesses were higher than you anticipated they would be or that you intended they would be for that particular stage?

A. No. Sorry, the reason I said "no" was because, when I had planned his fluid, I had, as you have seen by my statement on 1 February this year --

Q. We're coming to that.

A. -- I had wrongly estimated or calculated his urinary losses to be 200 ml per hour when I reflected on my practice and therefore, my fluid balance subsequent to the statement -- the table was made out subsequent to that statement, so my fluid plan had been based on my incorrect assumption of his 200 ml per hour urine output. So therefore, this table does not reflect my plan back in 1995 for Adam, if you understand what I mean.

Q. I'm not entirely sure that I do. Let's hear that again.

A. When I was asked to make out my fluid table, this current table, I was asked to look at his daily intake and his hourly urine output, as you've previously led me through that calculation.

Q. Yes.

A. This table was made out with the fact that he had a fixed urinary output.

Q. Ah.

A. So therefore, that is something that I have come, on reflection, to agree with the experts, that I now agree that he did have a fixed urinary output. But what I'm trying to say, albeit badly, so you obviously don't understand --

Q. No, I am understanding you now.

A. -- is that in 1995, for whatever reason, I miscalculated

his urinary output for the time period of his operation to be 200 ml per hour. I accept that that was a miscalculation and my fluids input was based on that miscalculation. So therefore, my fluid plan in 1995 was not reflected by this table.

Q. So this is not a fluid plan of your calculation in 1995, what you did and what would have been the result of that; this is a fluid plan based on the fact that you now appreciate what his urine output or his hourly urine output actually was?

A. Or as close as --

Q. Or as close as you can, yes.

A. Judging by the caveat already that there are hourly timelines that I wouldn't have necessarily planned for.

Q. I understand. Let's go to your most recent statement now that you mention it. It's to be found, at least the place I want to go to it, is witness statement 008/6, page 1. The purpose of putting that statement -- and there is something -- I do apologise. There's something I should have asked you right at the beginning. Now that I see that front page, I'll ask it to you now.

You, like a number of other witnesses that the inquiry is going to ask to assist in the oral hearing, have made a number of statements. You have made a deposition for the coroner, you have made a number of

statements for the inquiry, and you've also got a PSNI statement. What I'm going to ask you is whether you adopt all those statements as correct at the time. We can see them listed there.

A. Yes.

Q. They range from 21 June 1996, that was your deposition, to the coroner. Then there's 18 July 2005. That was your first inquiry witness statement. Then you had an interview under caution. There's your statement there of 17 October 2006 and we've all got the transcript of that. Then you had a second inquiry witness statement of 16 May 2011, a third of 28 September 2011. And as it would appear, another one, the same date, 28 September 2011, that was your fourth. Then you had your fifth, which is the one we have just been looking at, with your table, that was 9 January of this year. And then you had your last one for the inquiry, the sixth inquiry witness statement, which I believe is dated 1 February of this year.

MR UBEROI: May I just ask perhaps the question to be clarified, maybe, just as to precisely what the witness is being asked.

MS ANYADIKE-DANES: I understand that.

MR UBEROI: He's obviously made the statements, but if he's being asked to adopt them as accurate, then that's not

the position based on the witness statement that we've been to from February of this year.

MS ANYADIKE-DANES: Yes, thank you very much, because it's actually a bit of a problem that I had myself.

So far as you are concerned, what is the status of all those statements in terms of their accuracy? Because they deal with a vast amount of information, not all of which has been covered in your most recent statement. So what is the status of them all?

MR UBEROI: Just to clarify, I'm not sure I understand when the question is: what is the status of them?

THE CHAIRMAN: Let me break it down this way.

In that list of statements, doctor, which Ms Anyadike-Danes has just read out to you from page 1, is it your position that at the time you made those statements, they accurately recorded the facts as you understood them and your understanding of the whole medical process at that time?

A. To the best of my ability, they were a summary or an answer to the required questions that were posed at that time.

THE CHAIRMAN: And then what Ms Anyadike-Danes was asking you was that, in February 2012, you volunteered the statement, and this is the first page of that statement that we're looking at.

A. Yes.
THE CHAIRMAN: And in that statement, as she will go on over the next few minutes with you, you have made a number of concessions that things which you said previously and understandings which you had previously were not accurate; right?
A. Yes.
THE CHAIRMAN: But what I think she was asking you was -- and I think you end, in effect, by saying that, for instance, you now accept that administering excess volumes of hypotonic fluids can lead to cerebral oedema or dilutional hyponatraemia. That was something which you hadn't conceded before. To what extent does this February 2012 statement change what we should understand from the early statements which were made out there?
A. This statement that I volunteered on 1 February was my reflection of what I felt to be my main areas of criticism. It was not a -- in the time available and with the inquiry originally going to start in a very short time, I reflected on my practice after, as I said, the expert witness statements had been made available to me in late 2011 and I made the statement as a result of that reflection.
MS ANYADIKE-DANES: Well, can I put it in this way -- and

I thank the chairman, and for that matter my learned friend, very much because it's an important area to get right. Because, as I say, you do have extensive statements, you cover a number of matters in trying to assist those who are putting questions to you. So what I'm trying to clarify is: if you haven't altered your position in this statement, are we to take it that everything that you have previously said stands?

MR UBEROI: He's just stated he did alter his position in this statement as a result of the expert evidence.

THE CHAIRMAN: Sorry, he did alter his position, but in a limited number of ways. For instance, just to give one example: he accepts that giving excess fluids of this type can cause dilutional hyponatraemia, but he does not say that he accepts that Adam did have dilutional hyponatraemia. Do we understand -- I think this is one of the points -- that he still does not -- because he doesn't say it in this statement. Do we understand that he still says that Adam did not have dilutional hyponatraemia?

MR UBEROI: If I may say, certainly that's really my point, that is a question where I can understand how the question is put and how the witness is to answer it.

But I think when there are so many statements and he's given his answer in a generic sense about altering

his position generically because of the expert evidence, perhaps it would be more helpful to him if the question is put in that way, where he is asked specific questions as to whether or not X is still X or Y is still Y in a way that he can understand. I think my position is that putting it in this generic sense makes it very, very difficult for him to know quite what's being asked.

MS ANYADIKE-DANES: I understand that. I'm not intending to create any greater confusion than I may otherwise do normally, but what I am -- this is a relatively short statement, okay? So if there is something that you haven't mentioned in this statement, you haven't sought to make a concession about it, you haven't sought to correct it or reinterpret a view that you previously had, you just haven't touched it, am I to understand then that that means if you have previously referred to something -- let's take something entirely neutral.

Let's say, for the sake of argument, you say, "So far as I can recall, I believe Dr Terence Montague arrived in the operating theatre at roughly 7 o'clock". I'm not saying that's a fact of the matter, I'm just giving it to you as an example. If you haven't arrived in this statement what time you think Dr Terence Montague arrived in the operating theatre, am I to take it that, whichever statement it is that

says that, is still your belief as to what happened, other than what you may now tell me in the oral hearing? That's the generic point that I'm trying to get at.

A. This statement was made, as it says, on the basis of the expert witness statements that were available to me in late 2011. I reflected on my practice, on my previous statements, as a result of that, and volunteered this statement -- prepared and then volunteered this statement on 1 February. Further expert witness statements have come to me, come to my attention, quite a number, and quite extensive.

Q. Yes.

A. And I have been reading them avidly and doing my best to interpret them as they stand, and also to interpret them in the light of my previous statements. So shall I say that in the 1 February 2011, this was what I had reflected on.

THE CHAIRMAN: 2012.

A. Sorry, 2012. I beg your pardon. So in this statement in 2012, I will have reflected on those areas that I felt I had to reflect on in the light of the experts' statements available to me from late 2011. But there may be -- I'm not saying there is -- there may be further expert witness statements that will have an impact on previous arguments, questions, answers, that

I have made subsequent to this statement. I don't know if that's helpful.

MS ANYADIKE-DANES: Yes, it's really the difference between factual matters and arguments that you advanced in support of things. I can see, I think, from what you are saying that some arguments that you advance in support of things might well be affected as you reflect on expert reports, but I don't understand you to be saying that that has changed any of the factual matters that you referred to in any of your previous statements. But if it does and we get to it in this hearing, obviously you can help us with that. But I think I do understand your position and I'm sorry if I posed questions in a way that cause you some difficulty.

MR UBEROI: Only to complete my position, I think the last sentence is right on the money in that, over an inquiry that's lasted so long and there have been so many witness statements, that, perhaps, is the fairest way to approach it with this witness.

THE CHAIRMAN: Let me tell you what my understanding is from this. This statement is a response to the inquiry's expert statements about, for instance, whether dilutional hyponatraemia could have been caused at all, right, and what does bring it about. But it's not a response to the factual issues as, for instance, to

what other anaesthetists were with you and what time they were with you and so on. It doesn't seek to address those issues; it's only a response to the expert reports once they had been seen by the doctor.

MR UBEROI: Yes, I don't wish to lapse into giving evidence, but that would certainly be my understanding of the answer he has given where this is a response to the expert evidence and the sting of the points made in the inquiry's expert reports.

MS ANYADIKE-DANES: Thank you. Sorry, we've got it now, Dr Taylor.

Can we go to 008/6, page 2? You say, as you have just been telling the chairman, that you have made this statement after reflecting on the criticism of your anaesthetic management of Adam in the expert witness reports that you received in late 2011.

Can I ask you why they caused you to reflect on your anaesthetic management of Adam and other reports -- and, for that matter, statements -- did not cause you to do the same?

Let me help you a little bit so I don't leave it open-ended in that way. You would have received a report from Dr Sumner, for example. We know you have because you've commented on it in your witness statements. He was the coroner's expert and you would

have seen his report. Then you would have seen the report of Dr Armour, her report on autopsy. You gave evidence at the inquest and you would have -- if you weren't literally there at the time, subsequent to that you have seen the depositions of the witnesses there. Then there was the PSNI investigation and you were taken through at length, on -- I believe, it was 17 October 2006, I think -- but in any event, thereabouts, at length by the PSNI on your evidence and putting to you a number of things that came from, if I can put it that way, Dr Sumner and others, for that matter.

And then, of course, you will have had the questions that the inquiry put to you, which were based on, although you may have appreciated it, you wouldn't have known it for sure, but were based on the guidance that the inquiry was getting. They started in July 2005 and have carried on until you respond to the last request we sent to you. You respond in that fifth statement on 9 January 2012.

So there's quite a bit of material and, for that matter, an awful lot of material has been available from time to time on the inquiry's website. So what I'm asking is why you did not feel that you were not able to reflect on your anaesthetic management of Adam Strain

until so recently.

A. I cannot explain why I did not reflect on the evidence that you have listed until the date, but certainly in late 2011, when particularly the expert witness statements of Doctors Haynes, Coulthard and Gross became available to me, was the point at which the reflection, the serious reflection, occurred and the statement was then prepared.

Q. I appreciate that, that's when it happened. The question I'm really putting to you is why it happened. The PSNI investigation -- the interview and the questions under caution that were put to you in October were extensive. We've all seen them. They were thorough, they were extensive, they were based on expert reports and they put to you, time and time again, the position of other experts. So it is difficult to understand that you were not reflecting on your position -- you were certainly responding to criticism being made of you, so you may say you weren't reflecting on it, but you were responding to it. And what I'm asking you is: how could it be that you could spend so much time addressing criticisms in that period and not, until February of this year, after having reflected on documents received at the latter part of last year, come to a realisation that there may be something in that

criticism of your management, your anaesthetic management of Adam Strain, and that you would have to concede some points. That's what I'm putting to you.

I understand that you did reflect at the end of 2011. What I'm trying to find out is how you could not, in all the circumstances, have reflected earlier.

A. Well, that is what I cannot explain.

THE CHAIRMAN: Sorry, doctor, can I just to develop this point? It's a matter of more concern to me that after Adam died, there is an autopsy conducted by Dr Armour, which gave a cause of death, which was, in essence, also the result of the inquest; right? And as Ms Anyadike-Danes has pointed out, you gave evidence at the inquest, and so did Dr Sumner. But we understand from what Professor Savage said yesterday that, even after the inquest, you did not accept the finding of the inquest, which meant you were rejecting Dr Armour, rejecting Dr Sumner and rejecting the finding of the coroner.

In order to do that, in order to adopt that position, I presume you must have thought long and hard about it, but maintained your rejection of all of their reports and findings; is that right?

A. I think I've said my concern at the cause of death as listed by the coroner was related to the discussion of

dilutional hyponatraemia as having been caused by this theory of Dr Arieff's and that, although I couldn't deny the fact that cerebral oedema had been the cause of death, that I felt that dilutional hyponatraemia hadn't, as described during that inquest, and my views on that was the area that I had difficulty accepting, not the fact that Adam had died of cerebral oedema and hyponatraemia, but the fact that it was this term ...

It has been put to me or I have reflected on it as a term -- it's a semantic that I was concerned about overly. I now recognise -- concerned about and I certainly now recognise that I was wrong. I ought to have reflected earlier and now accept the coroner's verdict and that Adam had a condition known as dilutional hyponatraemia leading to cerebral oedema.

THE CHAIRMAN: So you do accept that Adam had dilutional hyponatraemia?

A. Yes, I do accept that Adam -- and I accept -- I think I say in the statement, which we'll probably come on to, that it was my miscalculation of the fluids that caused the dilutional hyponatraemia.

THE CHAIRMAN: Because you didn't say in the statement that Adam had dilutional hyponatraemia. That's not in the statement, which Ms Anyadike-Danes has referred you to. It's a point I made a few minutes ago to Mr Uberoi.

Are we now to read that statement as you accepting that Adam had dilutional hyponatraemia?

A. I apologise if there's any confusion left by my use of the words. I did mean and I do stand by the fact that I accept that it was my miscalculation of urine output that led me to give the inappropriate amount of fluids that led to a drop in his sodium called dilutional hyponatraemia, which led to cerebral oedema.

THE CHAIRMAN: Which in turn led to his death.

MR UBEROI: Well --

MS ANYADIKE-DANES: I was going to take him to it slightly differently than that way.

MR UBEROI: In light of the inquiry's own expert evidence, that is a slightly different issue now. I do think, in fairness Dr Taylor, he has been clear in answering your query about dilutional hyponatraemia.

THE CHAIRMAN: That certainly helps.

MS ANYADIKE-DANES: Thank you, Mr Chairman. I was going to come to that in a slightly different way.

If we can go to 008/6 at page 3. Sometimes, Dr Taylor, there are language issues and I think you've adverted to maybe one and one perhaps needs to be ... Microphone? Okay. Sometimes there are language issues and we pick up on things and we put some emphasis on them that maybe is not appropriate because you didn't

intend to -- or the person didn't mean it in that way, so please correct me if I'm doing that. We're just dealing with words; this is our opportunity to ask you in person things. That very first sentence, you say:

"At the time of Adam's transplant operation, I appear to have made the assumption that he would pass around 200 ml per hour of dilute urine."

Just so that we're clear on it, did you appear to do it or did you do it?

A. I did do it.

Q. Thank you. It's one of those language things, I suspect.

A. My expression often lets me down. With respect, I think you're overanalysing my words. I'm not that clever with English. I failed my English O level. I had to repeat it.

Q. You may not be the only one in this room.

A. It comes, from time to time, that I often express myself wrongly. I appreciate the opportunity that you've given me to clarify that Adam -- that I did miscalculate his urine. I have unambiguously said that I miscalculated his urinary output.

Q. I'm not trying to make anything out of it; it's just so that we are clear about these things. And that's one of the benefits of having an oral hearing: if there are any

of these sort of infelicities of phrase, we can get them clarified.

One thing, though, that might help is why you did think he could pass 200 ml per hour of dilute urine.

A. Well, this is part of my reflective process. It may go -- although I can't explain why it took so long, but this is something that I have been thinking about over the past 16-and-a-half years. I truly can't explain it. I understood Professor Savage did tell me that he had a fixed urine output. That's what I was told. I made my own independent assessment of Adam and I miscalculated his urine output and that led me to give the wrong amount of fluid.

Q. Yes, but let's be careful about that. You've just said that Dr Savage, now Professor Savage, had told you that Adam had a fixed urine output. Is that correct, is that what you're saying?

A. I believe he did and I've read his evidence that he did, although at the time I have said that I didn't remember the conversation he gave me. And this is again part of the confusion as I re-read all the different statements: things come back that I wasn't sure I knew at the time, but when one reads them multiple times over the years, then one becomes confused that maybe one did hear it at the time, but I can't be sure I heard it at the time

or whether I read it in a subsequent statement.

Q. I certainly understand that sort of process. Can I maybe help you in this way: at the time when you were making your calculations, your estimations or developing your fluid plan for Adam -- let's call it loosely that -- at that time to, the best of your ability, did you think he had a fixed urine output or not? Forget about whether you can remember whether Dr Savage told you that or not: did you think that?

A. I can't remember, and to try and say yes or no would be speculating. So I have to say I can't remember.

Q. That's fair.

A. I'm trying to be helpful.

Q. No, no, that's fair. You're not the only witness, I'm sure, who's going to say they can't remember something. Let's try and approach it this way. Can you help us from where you might have got 200 from? You have clearly got to form some view as to what his urine output is. That's a major factor in the calculations that you're going to make or the plan you're going to develop. It's one of those things: you have to work out how much you're going to put in, you have to work out how much you think is going to come out. Where did you get 200 from?

A. Well, we're in the realms of speculation, which I'm ...

I'm reluctant to do.

Q. All right then.

THE CHAIRMAN: You can't remember?

A. I can't remember -- the best guess -- if you'll accept it as a guess and a speculation -- which, as I say, I'm reluctant to say it -- but he was getting IV fluids -- sorry, PEG feeds overnight at 200 ml an hour, and I wonder -- it's speculation -- did I make an incorrect assumption that what goes in, must come out. And I failed. I can't remember exactly my thought processes at that time, but I wonder did I mistakenly feel that his output varied so that he passed more urine at night than he did during the day. And having reflected on that, I don't know if that was the reason why I did it, but having reflected on that I know I shouldn't have done that if that is what I'd done and instead have averaged his urine output over a 24-hour period as a fixed output, which I now accept.

MS ANYADIKE-DANES: Does that mean that you didn't appreciate the features of his polyuric condition or the way his kidneys would work in this period of end-stage renal failure? Is that what that really means?

A. Well, you're asking me to speculate again.

Q. I'll ask you as a matter of fact. Did you understand the implications for his urine output of his condition?

A. I can't remember if I understood that to be his condition.
Q. Had you ever anaesthetised a child in end-stage renal failure?
A. Yes.
Q. Had you ever anaesthetised a child who was polyuric?
A. Yes: Adam.
Q. Adam.
A. But he wasn't having a renal transplant and it wasn't at night.
Q. No. What I'm asking you is about the basis of your understanding for what his urine output would be -- that's a factor in what you would have to calculate for his fluids -- did you have to calculate the fluids that you had to give him previously -- had any previous procedure for which you have anaesthetised Adam required you to calculate his fluids for fluid management? Sorry, to be accurate.
A. I did look back over my anaesthetics that I did with Adam when I looked at his notes, and in the main they were short procedures. I believe he came to theatre on occasion with IV fluids running. So I didn't necessarily ... As I remember -- and I'm prepared to check this if necessary. As I remember, there were no fluid shifts necessary or blood loss expected during

those procedures before. Whereas this operation did -- I was expecting a lot of different fluid shifts and blood loss, so I did perhaps think more about his fluid calculations than I had done previously and possibly that's where the error crept in.

Q. So if we leave Adam out of it in terms of anaesthetising a child who is either polyuric or in end-stage renal failure, have you anaesthetised any other child who is in end-stage renal failure or polyuric -- prior to Adam, I should say?

A. I believe the patients I anaesthetised before with end-stage renal failure -- I have no list of cases, I'm afraid, to offer to you -- were anuric. In other words, they did not have native kidneys that passed any urine.

Q. So was this --

A. Until Adam --

Q. Sorry, I thought you were pausing there. Please continue, I'm sorry.

A. What I'm saying, I think, is: until Adam, I had not anaesthetised a polyuric renal failure patient before.

MR UBEROI: Sir, I'm sorry to interrupt my learned friend's flow, but whenever this passage of questions is finished, I just note the time in terms of a break.

THE CHAIRMAN: Yes. If you finish this sequence.

MS ANYADIKE-DANES: It probably goes on a little while,

Mr Chairman.

THE CHAIRMAN: Okay. Doctor, I don't know if you've been here for the last day or two, but we have to break for a while for the stenographer to rest and we'll start again at about midday.

(11.45 am)

(A short break)

(12.08 pm)

MS ANYADIKE-DANES: Dr Taylor, we're still in the urine output area, trying to work out how you got to the figure that you actually used. So where I was just about to take you is to ask you whether -- you may, in a way, have already answered this, but I'll put it to you -- when you considered Adam's medical notes and records, you found any reference there to his urine output being 200 ml an hour.

A. Yes. Well, I did look at his medical records, but I can't remember what was contained in the notes now. But I did not -- I feel I did not find -- no, I did not find any reference to urinary output of 200 ml an hour. I've said that I independently estimated that and it was wrong and it led to the error.

Q. I know that and I don't want to keep going over the same ground, but where we are at is not so much your appreciation now that it was wrong and its consequences

at the time. What we're trying to understand is how it came about. It may be that our ability at this remove with you to understand that is highly limited, but if you'll forgive me I'll press on a little bit and then we will see whether it is.

When you are formulating your fluid management plan for Adam and you're trying to get a sense of what his hourly urine output is as part of that plan and you used 200 ml an hour, and you've explained -- or at least you've surmised -- how you might have come about that figure, even though it's not recorded like that in any of his notes. Did it occur to you whether that could possibly be correct? If that was his hourly urine output, what that would actually mean in terms of his input, his daily input? Did it occur to you to sort of cross-check yourself in that way?

A. No. I feel I've speculated enough. I have said before that I can't explain where I got the number 200 from, but I'm not prepared to speculate further.

Q. I understand. If you can't remember, then I understand that. But it is the case, isn't it, that that would imply something like 4.8 litres per day if you were on the -- if you gross that up to get his daily urine output and then, if you worked on the basis which you told us before, that he sort of zeroed out -- as much

went out as came in -- that would amount to about 4.8 litres a day on that basis. Just as a matter of pure arithmetic, would it not?

A. Yes, it would.

Q. And I take it there's nowhere in his notes that you have found that he was ever administered 4.8 litres a day?

A. No.

Q. Thank you.

THE CHAIRMAN: And that would be extraordinary at that level, would it, 4.8 litres?

A. I don't know.

THE CHAIRMAN: Okay.

MS ANYADIKE-DANES: Sorry? Are you saying that you don't know whether it would be extraordinary for a four year-old child of 20 kilos to be administered 4.8 litres of fluid a day?

A. I'm not prepared to speculate.

Q. I'm not asking you to speculate.

A. You're asking me a hypothetical question and I am unable to go into a hypothetical mode --

Q. Sorry, Dr Taylor, I don't wish to press, but it's not entirely hypothetical. You're a consultant paediatric anaesthetist and that's certainly what you were at the time. I'm asking you, as a consultant paediatric anaesthetist, whether the administration of 4.8 litres

of fluid a day to a four year-old child weighing 20 kilos would be extraordinary.

A. It is a very large number for any child to take in in a day --

Q. Thank you.

A. -- in health.

Q. Can we now go back to something that I was asking you just before we had the break, which is your actual understanding of what Adam's condition implied about his ability to excrete urine? Did you understand his condition?

A. I believe I did.

Q. When you look back at it now, having had your period of reflection, do you think you understood it at the time?

A. I did. I do.

Q. And just so that we're clear on it: at the time, did you think he had a fixed urine output, that that was an implication of his condition, or a varied urine output at the time?

A. The evidence suggests, when I reflected on it, that he had a fixed urinary output. Having re-read his notes so many times, it's clear that he had a fixed urinary output. For an unexplained reason, I miscalculated it to have 200 ml an hour urinary output at the time of theatre.

Q. Yes. I'm not going to overly dwell on it, but I'm not sure that has entirely answered it. What I'm trying to get at is not whether you thought, for whatever reason, it was 200 ml an hour, but whether you thought he had a fixed urine output or not. You clearly think he does now -- or at least after your period of reflection and you've seen what the experts have said and so forth -- you think he did. What I'm trying to find out is whether you thought it was fixed at the time.

A. Well, if I thought it was fixed at the time, I wouldn't have thought he would get 200 ml an hour of urinary output.

Q. Thank you. That is helpful. Can I ask you what precisely you saw at the end of last year to lead you to appreciate, on reflection, that you were in error and, actually, he had a fixed urine output and it wasn't 200?

A. As I've said, it was the weight of the CD-roms, the CDs that I received in late 2011 with the expert witness statements from, I believe, Doctors Coulthard, Gross and Haynes, and they all were heavily critical of my management of Adam and had all ... There was some disagreements between the experts, but mainly they were all in agreement that Adam had a fixed urinary output and that my management of his intraoperative fluids was incorrect and were critical of that.

Q. I understand that and I understand that you have acknowledged that criticism, accepted it. I do understand that. But we are trying to understand, for the benefit of everybody, what happened in 1995. You've said that you thought you did understand Adam's condition and its implications for urine output. And even on reflection, you still are of the view that you had understood it in 1995. So you have read the experts' reports, it's really not just a matter of whether it could be 200 or whether it's fixed. Part of what Dr Coulthard and Dr Haynes and certainly Professor Gross are saying is that's a feature of his condition. This is not just Adam; that's what end-stage renal failure does: it prohibits the kidneys from responding in that way, so they don't vary output, vary the concentration of sodium. That's the whole point.

So what I'm putting to you is that not just [sic] a matter of fixed or 200 or whatever, but if you've got a child with that kind of condition and you had had the care of children with end-stage renal failure, why didn't you appreciate that what you were really dealing with is a child with fixed urine output that could not respond?

A. Sorry, could you summarise that again?

Q. If you understood his condition as you've said you

thought you did -- and I appreciate it's with hindsight. You're looking back at 1995, I understand that. But if you understood his condition, how could you not have appreciated that a feature of his condition is that his urine output would be fixed?

Let me help you with something that you have said before.

THE CHAIRMAN: Sorry, I missed the answer. Can you answer that, doctor?

A. I was about to attempt to.

THE CHAIRMAN: Okay.

A. I believe that I understood what chronic renal failure in polyuric patients meant and that meant patients like Adam would have a fixed urinary output. For some unexplained reason, which I now regret, I miscalculated and for some unknown reason, which I can't explain, I made an assumption, which is false, that he could pass 200 ml per hour.

MS ANYADIKE-DANES: Well, let me take you to where I was going to try and take you, to help you with that. Can we pull up 093-038-195? Sorry, let's start at 194.

This is the transcript of your PSNI interview. You are there talking about how you're dealing with his fluid management. If we start with you, I think it's your name, second up from the bottom, third up from the

bottom where you refer to having to get ahead of yourself and:

"... provide an environment where I was dealing with no deficits. That these kidneys, which were like a tap ... A tap was turned on."

Can we go over to page 195?

"I was trying to fill."

Then you refer to it being like a sieve, rather running out of the bottom, "there was a hole in the bucket":

"In crude terms, there's a hole in the bucket. I had to get that bucket filled up and keep it full."

Then if we go to 093-038-241. Your name, four down:

"You've failed to account because the taps are on the bottom end, as much fluid as I pour in, pours out."

And then the extra comment there is from the interviewer:

"But that's not true, doctor, in this case because you put in 500 ml in half an hour and he is only losing, you say, 200 ml an hour."

"No, we know his minimum urine, blood urine loss was 200."

Then you say, "because he can't concentrate his urine", and then you say:

"So we've never known about Adam and it's

a possibility, is it, if you give him 500 ml he can pee 500 ml. His kidneys are sieves. No one knows what the maximum urine output of Adam is."

Then it goes on. If we go over the page again, 093-038-242. After the earlier reference:

"He might pass 500 ml an hour ... Or 250. No one knows what Adam's kidneys are capable of. The only thing we know is he passed a minimum amount of urine which was 200 ml a day and my knowledge of Adam at this time was that this was a minimum loss and, in fact, my knowledge of the kidney disease was that there may be an unlimited --"

That's the point, Dr Taylor. In your reflection, do you consider that you understood Adam's disease and its implications for his urine output at that time in 1995?

A. Well, those statements are clearly wrong and I apologise for the analogy of the bucket. That is not a very nice way to describe what was happening. It was done in a way to try and explain what my thought processes were. So please, whoever, please accept an apology for that analogy. It's a very poor and painful analogy.

Q. I understand.

A. Secondly, I think that my thought processes at that time were clearly disturbed and I was not accurate in my description of Adam's renal losses. So it's clearly not

a statement that I'm prepared to accept. I regret saying it. It's clearly wrong and it doesn't reflect my knowledge of renal failure at that time.

Q. At that time. So two things: if it doesn't reflect your knowledge of renal failure at that time -- well, at that time, I'm meaning 1995 as opposed to literally at that time when you're making that witness statement, which was I think in 2006. How could you come to say it? I can take you through it. You are repeatedly pressed by the interviewer to try and explain that and your firm view is, effectively, that Adam's urine output was unlimited and could respond to ever increasing amounts of fluid administration. That's a fundamental difference between taking that view of the implications of somebody's disease and, on the other hand, understanding that the implications of the disease mean that their urine output is actually fixed. If you understood it was fixed, how could you possibly be explaining it in those terms?

A. I accept that my several statements on this idea, this notion of a large unlimited urine output does not apply to a patient with chronic renal failure, polyuric chronic renal failure. I regret saying that. It's clearly wrong. But I cannot explain why I said that.

Q. You said you were disturbed at the time.

THE CHAIRMAN: What did you mean when you said, "My thought processes were clearly disturbed"? "Disturbed" seems to mean something more than "wrong".

A. Adam died on the operating table. It's very unusual for a patient of any age to die on the operating table and has a devastating effect on the operating department. When a child dies on the operating table, which is an uncommon -- I know he didn't die, in fact, that he was taken off the ventilator in the operating department, but, effectively I ... I had expected Adam to have died during or after his operation and that was a devastating experience, primarily for his mother and his family. I don't mean to try to put the devastating effect of myself with the operating staff in the same league --

THE CHAIRMAN: I understand.

A. -- as the loss to the family. That's not what I'm trying to establish.

THE CHAIRMAN: I understand that. But in essence, you're saying --

A. Sorry, it left me personally very disturbed. As I say, not to the degree of his loved ones. The other thought that, in some way, I was responsible for the condition and the death of Adam was another blow. I have found over the years, with the questions that I've been asked and the statements I have made, that it is difficult to

cope with my thought processes, going over such a devastating event. I think that has permitted me to say things that are clearly irrational, wrong, disturbed, confused, and I offer that as an explanation for making such really outrageous statements.

MS ANYADIKE-DANES: Thank you.

Mr Chairman, for me, I wonder if we could have a five-minute break.

THE CHAIRMAN: Okay. Thank you.

(12.29 pm)

(A short break)

(12.41 pm)

MS ANYADIKE-DANES: Thank you, Mr Chairman. I appreciate that. I realise the timetable is tight.

Dr Taylor, if you understood Adam's condition and its implications at the time, you're an experienced anaesthetist: what could possibly have happened on the morning of 27 November to lead to that kind of error? And, for that matter, an error that is sustained over four hours or so of surgery. What could have happened?

A. I have obviously reflected over the years on that, even in advance of my statement, and despite what I said, in the years intervening. It was, I believe, an uncharacteristic error of judgment. I've looked at the circumstances that led me to anaesthetise Adam on that

particular time and the team that I had assembled round me. I felt I had a good team. I felt I had Professor Savage beside me, two surgeons, a nurse who could assist me with anaesthetics, an MTO who could assist me with anaesthetics and Dr Montague, who I knew, who was experienced and suitable to assist me. And yet it still went wrong.

It is uncharacteristic. It's never happened before or since, I'm glad to say, and it shouldn't have happened. I believe it was avoidable.

Q. I understand that. Well, let's try and get back to November 1995. You were on call that weekend; is that right?

A. I was on call that weekend, yes.

Q. And did that mean you were actually anaesthetising that weekend or you were just available, should you be required?

A. Well, my usual practice at that time was to be in theatre on Friday morning, Friday afternoon, and then be available for paediatric intensive care unit and theatres on Friday night. On Saturday morning, I would do a ward round in the paediatric intensive care and then assist with any emergency operations in the theatre throughout Saturday and Saturday evening, and then Sunday, again, to come in and do a ward round.

Q. Sorry, pause there. What happens on Saturday evening?
A. Be available. I don't live in the hospital, but I'm in the hospital from time to time throughout the weekend. I have tried to look back over the records of what my workload was that particular weekend, but it is divided between the intensive care unit, the theatre and the Emergency Department -- the A&E Department as it was called -- so I'm available to assist with any anaesthetic emergencies and intensive care patients.
Q. You had said that you had looked back over the papers to try and see if you could identify what your workload was and you said you hadn't been able to do that. Do you know if, on any of those evenings, you were actually in theatre?
A. I've been unable to find any record of how often I was in. There is a theatre book that would say what operations were done, but I wouldn't necessarily be in for all the operations. I would supervise the trainee anaesthetists from a distance and, of course, paediatric intensive care unit would not log the times that I would be called in to admit a new patient or to deal with an emergency in the paediatric intensive care unit.
Q. Does that mean you're on duty, effectively -- if we use on call as being on duty as well -- from Friday morning right through to Sunday night, and then you came back on

again for Adam's procedure on Monday morning?
A. No. Well, I would have been on call to 9 o'clock on Monday morning as an emergency on call, and then in the hospital on Monday to also provide anaesthesia or -- I can't remember what I was involved in on Monday. It would most frequently be with the paediatric intensive care unit --
Q. Maybe you can clarify it in this way. You're on call over the weekend; is that right?
A. Yes.
Q. So you're on duty on Friday in the normal way?
A. Yes.
Q. And then you're on call, and on call means that you're on call on Friday evening, does it?
A. Yes.
Q. Saturday and Saturday evening?
A. Yes.
Q. Sunday and Sunday evening; is that right?
A. Yes.
Q. When would you next start a normal day?
A. Monday.
THE CHAIRMAN: Monday at 9 am?
A. Yes, it would have been my regular workload, yes. At that time.
MS ANYADIKE-DANES: Being on call in that way might mean

that you were making any number of visits to the intensive care, paediatric intensive care, perhaps doing a procedure, answering queries from junior doctors or -- is that what that means, being on call?

A. Yes, it would be --

Q. Available?

A. No, paediatric intensive care is a consultant-led speciality. If a new admission comes in, a consultant would invariably be there to admit the patient, stabilise them.

Q. And that would have been you if that had happened that weekend?

A. Yes, and it could have been that I was there for an hour or, on occasions, not get home for prolonged periods.

Q. And then if you start your normal day again on the Monday, what happens? Do you work through until when?

A. Well, it would depend on how fatigued one felt and colleagues -- we have a good working relationship with our paediatric anaesthesia colleagues. They're a good bunch. We will take care of each other. So if somebody has a particularly busy or onerous weekend, then we will do our best to make sure the rest of us can cover for that person while they go off early. But it could be that you're in until 6 o'clock, a full day's work, following a weekend. We don't work like that any more,

we split our weekends, I should say.

Q. When did that start?

A. I don't have a date for that.

Q. Sorry, roughly. I don't mean the literal date. Roughly, when did that start? European directive?

A. No. Yes. Consultants aren't too bound by the European directive; junior doctors are. I would say in the last five years. But that's a speculation. It's a guess. I should also say we are working towards splitting the rota, in other words that there is a different consultant on for the paediatric intensive care unit at night and weekends to the consultant who's on call for the operating department. So there are two consultants available most nights in hospital, but not every night and every weekend.

Q. If you can't answer this say so, but if you're dealing with a transplant case, is there a pressure to participate, to give the child a chance?

A. I don't know what you mean by "pressure".

Q. Well, do you make extra special efforts to agree to anaesthetise so that the surgery can take place?

A. Well, it would be treated as any other case that presented itself to the operating department on a particular night or weekend or day. So, yes, you're -- I would have been the anaesthetist available

to anaesthetise Adam that weekend, so that was my job.
Q. Well, if for any reason you hadn't felt up to it, how easy was that to acknowledge?
A. If I had been overtired, I would have had to make a judgment to say I was not fit to present myself to start the case.
Q. I understand that. That's why I asked you. How easy would that be to acknowledge?
A. It would have happened from time to time. I can't enumerate the number of times it would happen. But there would be occasions when the workload was particularly onerous and I think that was what Professor Savage talked about yesterday: that a judgment would be made about when one would feel rested and to go for the morning. I think there was a decision made to delay the transplant until the transplant surgeon and anaesthetist, in particular, could rest prior to that to make sure they were fit and fresh, is the word that was used, I believe.
Q. I think it was, actually. If you had said that, "I just am too tired, the workload's been too onerous", or some other reason, so if you'd said that, "I'm afraid I don't think I could safely anaesthetise this child" -- if you had said that, who else was available as a consultant paediatric anaesthetist? Do you know? You may not

know.

A. Nobody was rostered to be available, but we are a good bunch and we will pick up the phone when we get a call and have, over the years, come in to help a colleague when it's been particularly onerous, such as the Omagh bomb, when several of us responded to help each other out. So there were infrequent occasions when the paediatric anaesthetist consultants would present themselves either on request or even without a request if they thought -- they heard on the news -- things were going to be busy.

THE CHAIRMAN: Can I just get it clear? The delay from operating at 2 am on Sunday night/Monday morning until, as it turned out, 7 am, was that for your benefit or Mr Keane's or both? Do you recall?

A. I don't recall.

THE CHAIRMAN: But it was, in effect, to your benefit in the sense that it gave you some hours' sleep, did it, or did it actually give you hours' sleep or were you called out to something else in between?

A. As I say, I've analysed, I've gone back over and tried to find out where such an error that I made could have occurred. I remember that the phone call from Professor Savage came at about 11 to 12 pm on the Sunday night, so that was bedtime. And then I got another call

from -- which I didn't initially remember -- from Dr Montague's statement -- at approximately 1.30 to say his drip had tissued and he wanted some advice on how to manage Adam's fluids. So that was another disturbed -- a disturbance and I don't remember any other calls until I presented myself to the hospital at approximately 5 am.

THE CHAIRMAN: Sorry, maybe I misunderstood you, but I thought that Professor Savage's first contact with you would have been before midnight. I thought that the call from --

A. Yes.

THE CHAIRMAN: -- from England, from the agency, to say the kidney was available, led him to speak to Mr Keane to confirm that it was an anaesthetist, which I thought meant talking to you to confirm that there was a theatre and so on. And then, all of those being set up and in line, he was then able to go back and say: yes, the kidney would be accepted for Belfast for Adam. I got the impression that that was late afternoon, early evening.

A. My recollection is that it was in the evening, late evening on Sunday.

THE CHAIRMAN: Okay, thank you.

A. But it is a recollection.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: Well, the position still seems to be that you can't explain how, with all your expertise and experience, you could make such a fundamental error. Is that what you're saying?

A. Yes.

Q. I'm just going to take you through the rest of this most recent statement. I don't think it will take too long.

I'm conscious that I required a break, sir. If the chairman permits, we may go a little bit past 1 o'clock. And then, when we come back after lunch, I intend to pursue chronologically through what happened and the events of 26 November.

So going back to your statement, which is WS-008/6, page 3. Then you say:

"When I commenced Adam's anaesthetic at around 07.00, I appear to have become preoccupied with the anaesthetic procedures: endotracheal intubation, insertion of a peripheral intravenous line, arterial line, central line, and epidural."

Pausing there. That's the explanation for why you omitted sending a blood sample. But just leave that. Those anaesthetic procedures, that's the same for any surgery, isn't it? Any major surgery? Those are the things you do?

A. Yes.
Q. I only ask because the way it reads in this is that, for some reason, there was something extra that you were caught up in and that's what prevented you -- or at least allowed you -- to omit to send a blood sample for electrolyte analysis. But there's no difference or anything special about those procedures, is there?
A. No.
Q. So then how is it that conducting fairly standard procedures led you not to send a sample for electrolyte analysis?
A. I have recognised, I think, that it follows to say that I ought to have sent a blood sample. Because of this, I deprioritised the sample, I should have sent it.
Q. Sorry, what led you to deprioritise?
A. The fact that the procedure -- I placed the procedures as a priority over the blood sample.
Q. Well, how difficult would it have been to have taken a blood sample once you've got that arterial line in?
A. The taking the blood sample would have taken --
Q. [OVERSPEAKING].
A. -- would be easy, but it would require to put that into a tube into a ... Um ... Request form to contact a porter --
Q. Yes.

A. -- to contact the lab and to get it -- that is not a reason for not doing the blood sample, and that is why I've --

Q. You haven't said --

A. -- admitted not doing the blood sample.

Q. Sorry, just to be clear about it, Dr Taylor: what you're saying here is that you omitted to send it because you were caught up with perfectly standard anaesthetic procedures at the beginning of an operation. That's what I'm --

A. Okay.

Q. -- asking you to address. If we just get that in context a little bit.

A. Okay.

Q. Professor Savage has said not only was it part of the renal protocol -- and we'll go through all that in the afternoon when we go through chronologically what happened -- but not only was such a sample part of the renal protocol, but he had expressly put to you that it would be a requirement and that's what you should do. And according to him, you had agreed you would do it.

So you don't have to wait until you literally get into the operating theatre. You know you're going to be doing, you know you're going to be putting lines in, some blood can easily be taken at that stage. Is there

anything wrong with having Dr Montague or any other person who you can find who's about -- you have nurses there and so on -- to just phone up the laboratory and say, "Look, I'll be sending a sample along and I'd like to get a response back from that as soon as I can"? What's wrong with that?

A. My recollection was that we were preoccupied with the lines and, if I can explain, an epidural requires one anaesthetist to be scrubbed with gloves and gown on and concentrating on doing the epidural. And because he's scrubbed with gloves and gowns on, he can't monitor the patient effectively and he can't adjust the ventilator or the oxygen or the anaesthetic gas settings because he's clearly got gloves and gown on. So my standard practice is for an assistant -- two anaesthetists, in fact -- to be present and Dr Montague was a trainee so he would have required supervision for doing the epidural placement. So I believe Dr Montague did the epidural, he was scrubbed and the other anaesthetist, myself, was then available to ensure Adam's safety in terms of his anaesthetic management.

And then when that was completed and, I believe, when the epidural was sited, we put Adam on to his back again and I scrubbed, put gloves and gown on, while Dr Montague managed Adam's anaesthetic. And I then

attempted to gain central venous access. So I believe that is what I meant by -- although when you see it written down on this page, these anaesthetic procedures are 1, 2, 3. In reality, with a child, these procedures can occupy a period of time and dedicate what I felt -- dedicate the important members of the team to Adam's side.

Q. Yes. It's not --

A. Proximity.

Q. -- not exactly what I was asking you. As you went into the operating theatre, you appreciated that testing Adam's electrolytes was not only something that was required by the renal protocol --

A. Yes.

Q. -- but it was something that Adam's consultant nephrologist had told you ought to be done. And in any event, it was something that you really ought to establish because you had no other information as to what his serum sodium levels were at that stage. So according to Professor Savage, you had agreed that that would be done. What I'm trying to ask you is: knowing that you're going to do that, could you not have made an arrangement for a porter to come so that the sample that -- you're going to have access to his blood anyway when you carry out some of these lines that you're going

to insert -- a sample could be taken, sent to the laboratory and you could receive a response. Why couldn't that happen?

A. Well, I agree with you, that is what ought to have happened and that is what I ought to have done. And I failed to do that. The only reason I can come up with for failing to do that is because I wanted to get the anaesthetic procedures done.

Q. But they're not mutually inconsistent, are they? It's quite possible to end up doing both, to be having all his anaesthetic procedures carried out and also having arranged for a sample to be sent so that his electrolytes could be tested. They're not mutually inconsistent, are they?

MR UBEROI: May I just rise and say, in fairness to the witness, he hasn't suggested they are mutually inconsistent and he's accepted he should have done it.

MS ANYADIKE-DANES: I'm grateful for that. I suppose what I'm trying to do and continue to do is to get some explanations as to why the things that Dr Taylor acknowledges he should have done or understood were appropriate, he nonetheless didn't do. That's what I'm trying to get at. I understand the point and I appreciate that, and if my questioning doesn't elicit that I apologise. But that's actually what I'm trying

to get at.

Because where you say here that --

THE CHAIRMAN: Sorry, could I just ask it this way: doctor, one way of interpreting this is for me to understand that you're not really putting forward any excuses or explanations. These things should have been done and they weren't done.

A. Yes, that's correct. I believe that's correct.

THE CHAIRMAN: What you're illustrating to us is how many other things are also being done at the same time so that we understand the complexity of the work which you have to do with Adam, which is not untypical, I gather, from the work that you do, but while the work is complex, there is really no good explanation for you not having done the things that you have accepted should have been done; is that fair?

A. That would be fair, yes.

THE CHAIRMAN: Okay.

A. I agree with that.

MS ANYADIKE-DANES: Thank you.

Dr Taylor, in that same paragraph you've also said that:

"I should have sent other samples as necessary and used those results to adjust the rate and type of the intravenous fluids."

Do you mean to say that you should have sent other blood samples for continued electrolyte measurement?

A. What I meant was that at periods throughout the operation I should have done regular blood samples to adjust my fluids to that, and I also failed to do that. So for some reason that morning, the blood samples were not -- I omitted doing blood samples as requested by Professor Savage.

Q. I accept that you are acknowledging that you omitted to do that. You had sort of attempted to try and explain how that might have happened at the start of his time in the operating theatre because there's simply quite a lot of set-up work to do and things have to get done and different people are doing different things and you omitted to do it. And although you say you can't remember if that's the reason, nonetheless you're trying to provide the context in which that might have happened. How might it have been that you forgot or omitted to send other samples as necessary? How could that have come about?

A. For that, I have no explanation.

Q. If we move on to the next paragraph, that deals with the central venous pressure, CVP, and the arterial blood gas sodium level. You say that there were concerns and that you had concluded that you were unable to trust --

I presume by "them" you mean the results that you were getting -- and therefore, you decided to pay them less attention than you should have:

"I felt the CVP catheter in Adam's neck and was therefore convinced that it was not in continuity with the great veins draining to the heart and could therefore not be relied upon. It also appears that I was concerned not to delay the surgeons with the implantation of the donor kidney."

There's quite a lot going on in that paragraph. What I'm trying now to see is what your present position is in this statement. You say that:

"[You] had become convinced that the CVP catheter was not in continuity with the great veins draining to the heart and [you] couldn't rely on them."

In fact, actually, you did rely on the CVP recordings; you relied on them for relative change. That's correct, isn't it?

A. Well, I stated that I did, but on reflection I'm not sure if I paid them the attention that I did, even when they were reading as a trend.

Q. No, sorry, let's be very careful about that. When you had given your previous witness statements -- in fact, not just your witness statements for the inquiry, but also, I think, the deposition to the coroner and also,

I think, the statement to the PSNI, your view was, because of where you thought the catheter was, you weren't getting an accurate recording and that was just that. I think at some places you refer to it being up a dead end or whatever it is, but, in any event, it wasn't accurate -- it was too high and not accurate.

But then what you went on to say is: but I could use it, but only for relative change and you knew what relative change you wanted to introduce. I think you refer to how you wanted, perhaps, at some stage to increase it by 5, maybe:

"So I could do that, but I couldn't use it as an accurate absolute number."

Have I summarised your position?

A. Yes, I think that was my conclusion at that time.

Q. Thank you. From what you've just said now, are you saying that you're not sure whether that's what you were doing, or are you saying you were doing that. But you weren't doing it as frequently as you should have been doing it?

A. Well, it was a continuous reading, it was always there, but I reflected over it and I felt that even when it was changing, it wasn't providing me with information that I was usefully using to manage Adam's fluids.

Q. When you say "usefully using", do you mean you weren't

paying sufficient attention to the relative changes or do you mean something else?

A. It was becoming less of a -- I believe that I was, on reflection, not relying on it as much as I ought to have in the context -- this was in the context, remember, of the expert statements from doctors Haynes and Coulthard.

Q. I would like to move you away from there and take you back to 1995 when your first statements were that, "I felt I couldn't rely on that high level", the initial 17, then it went up to 20 and so on:

"Couldn't rely on that ... just didn't think the catheter was in the right place. It had gone up towards the neck as opposed to down where it should have gone."

That's summarising it in layman's terms. So:

"I couldn't rely on that figure, but I could use it as a marker for relative change."

And what I'm trying to find out from you is: is that what you still think you were doing at the time or, on your reflection, do you now think you weren't doing that? That's the first question.

A. It certainly was clear to me on reflection, and at the time, that CVP was giving me problems. I was not happy with the CVP. I thought I could use it as a trend in one statement and I attempted to use it as a trend. When I reflected on that, I'm not sure that I gave it

the attention that it deserved. In other words, I'm not sure if it was as useful as a trend as I had originally discussed, presented.

THE CHAIRMAN: When you say you reflected on it as a trend, do you mean that you reflected on it after Adam's death when you were going back in your mind over the different events and making statements, or do you mean that you reflected on it during the treatment of Adam?

A. I think the first scenario that you said, the former.

THE CHAIRMAN: What you said was: when I reflected on that, I'm not sure I gave it the attention it deserved. And what you're saying is when you were making your various statements to different people at different times, you are not sure that you gave it the attention in November 1995 that it deserved?

A. No. Sorry.

MR UBEROI: I only rise to assist. It seems the witness is potentially confused. I don't know if a reference may assist.

MS ANYADIKE-DANES: Just what I was going to do. Let's start with the deposition for the coroner. That's 011-014-099. If you can go about two-thirds of the way down, you'll see reading and then, in brackets, "17". Do you have that?

A. Yes.

Q. So if we go a little bit above from that so we can see the context:

"However, from the pressure reading, I concluded that the tip of the line was not in close relation to the heart (later confirmed by X-ray). I therefore used the initial reading (17) as a baseline."

And then I think if we go to witness statement 008/1, page 5.

MR UBEROI: Sorry to rise again. I was just waiting to see if it would be a brief question, but in view of the time, it is lunchtime, and I do wonder if this might be an appropriate moment to break for lunch.

THE CHAIRMAN: I was going to ask. Is there a question about the last document?

MS ANYADIKE-DANES: Yes, I'm just going to ask the question now. The two go together.

THE CHAIRMAN: Let's do this. We'll break in the next few minutes, Mr Uberoi.

MS ANYADIKE-DANES: If you go to the penultimate paragraph, which starts "the computerised record"; do you see that?

A. Yes.

Q. "The computerised record indicated that Adam's CVP was initially 17 and had risen to 20 at 9 am -- a modest rise of 3 in two hours of surgery. Although the initial CVP of 17 is higher than normally expected, we concluded

that the tip had curved upward into the neck vessels as confirmed by the compression. Therefore, as indicated in my statement [that's the one I just took you to], we accepted 17 as a marker to look for a relative change rather than an absolute level."

So the question I was putting to you is: were you accepting that that is what you were doing in 1995? And is your concession that you should have actually been looking at those relative changes more often or are you saying that you should actually have looked at the absolute level and not got into the business of relative change?

A. Well, I think the absolute level is not what I was looking for. I think there was an indication the absolute level was incorrect, and that questioned the reliability -- the entire reliability of the whole line.

THE CHAIRMAN: Well, if the entire reliability of the whole line was in question, are you saying -- I know you've been through this a number of times. But putting yourself back as best you can to November 1995, are you saying that since the absolute level was incorrect, you did rely on changes in the readings as markers?

MS ANYADIKE-DANES: Yes. And then my final --

A. Yes.

Q. -- question is: is the concession that you made -- and

we go back to witness statement 008/6, page 3. And this is my final question, I know you've been there a long time. The whole paragraph, apart from the bit at the end to do with the surgeons, is dealing with the reliability or otherwise of the central venous reading. You say that you had concluded that you couldn't trust them and you've just said that that is what you concluded, except for the purpose of relative marker, and therefore decided to pay them less attention than you should have.

What I'm trying to get at is whether you are now accepting that you should either have looked at the relative changes more often or you should have paid attention to the absolute figure. They're two different things and I'm simply trying to clarify what it is you now say you should have paid more attention to.

A. Okay, I think I understand what --

Q. Thank you.

A. -- my own interpretation of this and my own feeling on this was. When the line was put in, it was clearly in the wrong place and although an earlier statement said I thought I could rely on it as a marker for central venous pressure, on reflection, in the context of the statements that were coming through in late -- which I couldn't divorce from my decision-making.

This means that I shouldn't have relied on that line at all and I thought about either replacing it in a different site, as one of the experts had said, using the femoral veins, for instance, or discussing with the nephrologist and the surgeon the possibility that Adam's transplant should not proceed. In other words, this potentially should have been a show-stopper.

Q. I understand. Thank you very much.

A. That's what I think I meant. That is what I meant by saying that I shouldn't have relied on the CVP at all because it was such an important device.

Q. Thank you very much, Dr Taylor. I wonder if at that point --

THE CHAIRMAN: Yes, we'll break now. I will resume at any time from 2 o'clock on as we can because Dr Taylor's position is quite clear to me, his personal position today is quite clear to me, and I'm anxious to get through his evidence as completely as we can but also as quickly as we can. So I'll be ready from 2 o'clock whenever anybody else is.

MR UBEROI: I do understand that, sir, but I'm anxious that -- it's detailed stuff, in places it's draining stuff, and I'm anxious that Dr Taylor has the same level of break that any other witness in this inquiry would have. So perhaps as a compromise, if I might ask for

2.15? I do understand the pressure.

THE CHAIRMAN: That's not a problem.

(1.21 pm)

(The Short Adjournment)

(2.15 pm)

(Delay in proceedings)

(2.25 pm)

MS ANYADIKE-DANES: Can we please pull up witness statement 008/6, page 3, please? Dr Taylor, I was asked if I could clarify a point that you had made in relation to the 200 ml per hour of urine.

If you look at the top of that page, the first paragraph, you can see that there's a final sentence that starts:

"The intraoperative fluid that I administered was based on this incorrect assumption."

The incorrect assumption being that he would pass around 200 ml an hour of dilute urine. Then you go on to say:

"And I therefore administered a hypotonic fluid [which is Solution No. 18] at a rate in excess of his ability to excrete it, particularly in the first hour of anaesthesia."

The point I've been asked to clarify is: what is the relationship between your understanding that Adam --

admittedly, you say that it's incorrect -- but at the time, that Adam could pass 200 ml of urine an hour and administering to him quantities of Solution No. 18. What's the relationship between 200 ml an hour and Solution No. 18?

A. Do you mean what's -- I administered 200 ml an hour.

Q. No, sorry.

THE CHAIRMAN: It's the word "therefore" isn't it?

MS ANYADIKE-DANES: It is, it's the word "therefore".

THE CHAIRMAN: If you look at that sentence, doctor:

"The intraoperative fluid that I administered was based on this incorrect assumption about the amount of fluid that Adam would pass."

Okay? And you say:

"I therefore administered Solution No. 18."

I think what you're now being asked is: is there any logical connection because that almost suggested because he could pass 200 ml an hour, if you hadn't thought that, you would have administered a different fluid. It's the "therefore". You say:

"The fluid I administered was based on the incorrect assumption about how much he could pass and I therefore administered Solution No. 18."

A. I'm sorry, I'm ... I'm struggling to ...

THE CHAIRMAN: Sorry, let me put it another way. Given your

incorrect assumption, would it matter what fluid you administered? He was always going to be in real trouble if your fluid administration was based on him passing 200 ml an hour.

MS ANYADIKE-DANES: Well ...

A. If I understand what you're saying --

THE CHAIRMAN: We're trying to understand what you're saying.

A. At the top -- sorry. The first sentence of that paragraph, I think I've said -- I have said he would pass around 200 ml per hour of dilute urine.

THE CHAIRMAN: Yes.

MS ANYADIKE-DANES: That's correct.

A. So I think my incorrect assumption was that that would have been a type of fluid -- a concentration of sodium, again incorrectly, that would match the type of fluid he was losing in his urine.

Q. Yes, thank you. Then what I wanted to move on to say is: had you not thought that he was going to pass 200 ml an hour of dilute urine, does that mean you might have administered a different solution?

A. Um ... I can't remember. I think that's a hypothetical that I can't ...

Q. Well, it is a bit hypothetical, but then you, if I may say so, have initiated the situation because I am trying

to understand the connection between:

"The intraoperative fluid that I administered was based upon an incorrect assumption ..."

The connection between that and when you say:

"So therefore I administered hypotonic fluid ..."

Which is Solution No. 18. If you hadn't had "therefore", I would be asking you the question in quite that way, but "therefore" does seem to me to imply a connection between the two things.

You may say, "Actually that was a mistake, I didn't mean there to be a connection", or, you may say, "Yes there is a connection, and it's explained in this way". That's all I'm trying to understand.

A. I think ... I don't know what to think. I'm confused.

Q. Okay. Go back to 1995. 1995, you've got a figure to put into your fluid management calculations or plan as to what his urine output is. Okay? You're going to have to have some figure about his urine output and you have it. Forget for the minute that it's incorrect: you have that figure and, so far as you understand it, that figure was 200 ml an hour.

A. Okay, I'm with you.

Q. What I'm trying to find out is: having formed the view that the urine output was 200 ml an hour, did that affect the type of fluid that you decided to administer

to Adam?

A. Well, again, I had made another assumption that his urine was dilute.

Q. Yes.

A. And therefore contained a lower concentration of sodium based on, again, an older urinary sodium of about 30 millimoles. So that was another issue because his sodium hadn't been measured and Dr Coulthard takes issue with the urinary sodium that was likely to have been excreted in 1995.

Q. Sorry to cut across you, but I'm less interested in Dr Coulthard at the moment. I'm trying to get us back to 1995. As I understand what you're saying, the fact that you had concluded his urine was dilute meant that you were going to administer a solution or fluid with rather lesser amounts of sodium in it, if I can put it that way; is that correct?

A. Yes, that would match as close as possible the sodium in his urine.

Q. So the connection is between the diluteness of his urine and the type of the fluid, and has nothing to do with 200 ml; is that correct? If he had produced 75 ml an hour of dilute urine, what effect would that have on the fluids that you would have administered?

THE CHAIRMAN: The type of fluid?

MS ANYADIKE-DANES: Yes, the type of fluid.

If you hadn't made that mistake and you had got the right amount, as you now believe it to be, the right quantity of urine being passed per hour, if you had got that bit right, it's going to be dilute anyway, you're told that --

A. I'm sorry to make you labour this, but I'm really not quite tuned in to what you're saying. I think the principle is that there's a volume that he's losing, which you have to replace, and there's a concentration that he is losing, which I feel I have to replace in a similar concentration. I don't think the volume I have to replace is related only to the volume he is losing, but also to the concentration that he's losing.

Q. I think you are answering --

A. So I would match both the volume and the concentration by a similar, if not identical -- it probably isn't going to be identical, but it will be as close as I can make it.

Q. So what it sounds as if you're saying is that the error that you made in terms of the volume did not actually affect the type of fluid you administered.

A. Um ...

Q. Because you were going to try and administer a dilute solution?

A. Yes.
Q. Right. If that's the case, then the "therefore" is a little misleading.
A. Yes. Okay.
THE CHAIRMAN: Sorry, just to clarify, I think what Ms Anyadike-Danes and I are on about is this: when you say, "I therefore administered a hypotonic fluid, Solution No. 18", it doesn't actually matter what fluid you administered. Is that what you're saying? Could you therefore be saying: I therefore administered a fluid at a rate in excess of his ability to excrete it? Whether that's Solution No. 18 or not.
MS ANYADIKE-DANES: Sorry, Mr Chairman, I would like to address that because I think that, actually, is a significant factor.
Sorry, there is then a difference between us because I thought where Dr Taylor had been is he was matching dilute solution with dilute urine and that meant Solution No. 18 with dilute urine. What he wasn't intending to say is the mere fact that he thought it was 200 ml led him to administer the Solution No. 18; the Solution No. 18 was being administered because the urine was dilute.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: Is that --

A. I think that's something I can understand.
Q. Thank you. Sorry, I had wanted to clarify that because there was some query as to what exactly you meant there, so I think you have clarified that now.

Then can we go back to where we were in the paragraph dealing with the CVP, which is the penultimate paragraph. I wanted to take you to the final sentence in that paragraph, which we hadn't reached before the break. So you had set out what you meant about the CVP and whether you could or could not trust and what you should or should not have been doing in relation to the figures that you received. And then you go on in this final sentence to say:

"It also appears that I was concerned not to delay the surgeons with the implantation of the donor kidney. I recognise that this led to a lower standard of care than I would normally provide."

What do you mean?

A. What do I mean by not wishing to delay the surgeons?
Q. Yes.
A. I was, on reflection, again, knowing the information that I had gleaned from the experts and, on reading the many papers, that the cold ischaemic time was a factor behind everything that was done in the operating theatre. And the timing of my element of his

anaesthetic was a factor in making sure the kidney was going to be transplanted in the optimum or best possible state. So when I reflected back on my practice and I inserted -- and I think I put it here because of the CVP.

Q. I understand.

A. And I felt that the difficulty or the unreliability of the CVP measurement was something that I was going to have to either go with, and I went with the CVP that I now was not happy with, and, on reflection, as I said before lunch, I felt the CVP in the state it was now in -- and reading the expert opinions -- should have made me discuss in greater detail or discuss in the first place with the surgeon and the nephrologist about whether this would even lead to a question of whether we should continue.

So in terms of the donor kidney sitting there, clearly there was -- I failed to, apparently, have a discussion with the nephrologist and the surgeon about whether we should proceed with the transplant at all and went on because the donor kidney was -- because of the cold ischaemic time. Sorry, that's a very long answer.

Q. No, no. It's your answer and that's what I'm trying to get. Before lunch, when you had been going through what your options might have been, yes, you did give that

option that you could have discussed matters with the nephrologist or the surgeons, I think you put it, and in fact the actual values that you were getting -- I think the expression you used was "might have been a show-stopper". In other words, it might have actually meant that you didn't proceed with the transplant.

Before you got to that possibility, you said: the other thing I could have done was I could have asked the surgeons to do a femoral cut down and put the central venous catheter in that way, which would have required the surgeons' assistance, and if you'd done it that way then you've got, have you not, a CVP measurement that could be relied on?

What I was going to ask you is: if you had taken that option, which you acknowledged yourself you could have done, what would you have considered to have been the delaying factor in doing that?

A. Well, I have experience of doing femoral central venous lines and they don't necessarily have to be cut downs.

Q. Okay.

A. I understand that this was an option raised by one of the experts, but I personally would not feel a femoral line will give me a true reading of a central venous pressure in a patient who's receiving abdominal surgery because the tip of the femoral line will lie in the

iliac or inferior vena cava vessels and that could be subject to some pressure by the interabdominal contents, particularly in this case with a large adult kidney being placed around the area of the inferior vena cava.

I don't know what the views of my colleagues would be, but my view at the time and now is that a femoral line, femoral access line -- and I know this is probably the first time this has been raised with the inquiry, but to me a femoral line would not have provided a reliable central venous pressure in a renal transplantation child. That's a summary.

Q. I understand. So from your point of view, there were only two possibilities: either you went on with the situation the way it was or you halted the transplant?

A. Or, as you suggested, I could have -- and I didn't -- discuss a femoral line with the nephrologist and the surgeon.

Q. Sorry, I thought you just told us that you wouldn't consider that to be reliable.

A. I wouldn't, but they might have had a different view, which I didn't negotiate, which I didn't ...

Q. Let's say you were going to do that, which is the option you have just said -- could have discussed that -- and seen whether the consensus effectively was that that would be an acceptable thing to do, to enable the

transplant surgery to proceed. What then is the delaying factor? I'm trying to actually find out how long you thought that the delay would be that gives rise to this concern about the cold ischaemic time.

A. Well, I think what I meant was that I had a line that was imperfect -- I've said that in my deposition -- which was the closest memory that I had to the time. And I made a decision to proceed with that line. But on reflection, I could have done two other options, which I didn't do. So I made a decision to go with the line that was imperfect and, on reflection, I have questioned that decision and I've come to the conclusion that I ought not to have relied on the central line as I did.

Q. Dr Taylor, I understand that. But what you have said in this statement is that you think, at the time, the reason why you didn't countenance doing anything else -- one of the things being this issue of discussing it with the surgeon -- is because you were worried about delaying them, and now you've expanded upon that a bit. The real source of your worry is that you were worried about the cold ischaemic time clock ticking, basically, I think is what you're saying?

A. And I feel that made me go with a line that was imperfect.

Q. I understand that. What I was trying to find out from

you is, if that was your thought process at the time, how much time is taken up with the alternative, which is raising it with the surgeons and, if they are of the mind, having a femoral line inserted?

A. Probably not very much time.

Q. I've no idea on the procedure. How long would the procedure take?

A. To site a line?

Q. Yes.

A. 20 to 30 minutes, probably.

Q. 20 to 30 minutes, and to discuss it, you just said not very long?

A. Not very long.

Q. Is that amount of time something that you felt would be critical to the cold ischaemic time?

A. Bearing the fact that I'd taken an hour to do my procedures to this point?

Q. Yes.

A. Well, as you say, the clock was ticking, and any further delay would have also affected the success of the kidney graft, the kidney transplant.

Q. Yes. I'm going to come to that in a minute, but what I'm asking you is --

A. I can't make a judgment about the survival of the time [sic], but I was cognizant of the need to get going with

the kidney. Maybe that clouded my judgment more than it should have.

Q. Right. Can I just put it to you this way -- and please correct me if I have incorrectly summarised the situation: the surgeon's concerned, all things being equal, in trying to produce a successful transplant result, a donor kidney, transplanted in there, working, performing for the patient; is that about right?

A. Yes.

Q. That's the surgeon's task. Your task is different. Your task is to make sure that the patient comes through that process, either -- well, firstly comes through at all and comes through in the best health possible. So your focus is the patient; isn't that right?

A. Yes.

Q. So what I'm trying to work out is: that's your priority; the surgeon's priority is the success of the kidney graft. And is what you're saying that you allowed your concern with the cold ischaemic time, which is essentially something about the success of the kidney graft, to be of a higher priority or to cloud your judgment as to your own responsibility to Adam's well-being?

A. Well, I think that's what I've said when I said:

"It also appears I was concerned not to delay the

surgeon."

THE CHAIRMAN: What is not clear to me is this: in this sentence that you're being questioned about, is this your best effort in February this year to think back or to rationalise what you did in 1995? Or when you say, "It also appears that I was concerned about delay", is that what you actually remember from 27 November 1995?

A. Sorry, could you just ...

THE CHAIRMAN: Let me put it maybe more clearly. Do I understand you to mean in that sentence, "It also appears that I was concerned not to delay the surgeons", are you saying, "I remember that on 27 November 1995, I was unhappy with the CVP and I might have taken one of the sort of options which is being discussed but I didn't because I was concerned not to delay the surgeons"? Do you remember that? Or is this you saying after you have read the expert reports, "Maybe that's what was in my mind". It's not clear to me.

A. I think that the second option is the one that would match my ...

THE CHAIRMAN: So this is a --

A. With the benefit of hindsight.

THE CHAIRMAN: On one view, it's a sort of after-the-fact effort to rationalise or explain what you did, but it's

not what you actually remember from 27 November?
A. I think that's what I meant, yes.
THE CHAIRMAN: Okay.
MS ANYADIKE-DANES: So does that mean that not wishing to delay the surgeons may not have played any part in your conduct at all?
A. I work as a team. I worked as a team with the surgeons. I think anything I did to Adam had an impact on the surgical success; anything the surgeon did to Adam had an impact on my success. So what I'm trying to say is: I don't think when you said earlier that I had the role of safeguarding Adam and the surgeon had the role of the kidney survival were two mutually exclusive events.
Q. Understood.
A. I think we worked together and the surgeon would be keen that I get my anaesthetic preparations done in a timely manner so that he can get his surgical procedure done in a timely manner as well. I think the two are connected.
Q. I understand that. We will address it later on, but all I was trying to understand from what you had said in this statement is whether concern about delay played any part in your decisions or conduct in relation to the CVP. It seems as if it did from this statement and I was simply trying to find out if that was, in fact, the case.

A. I think the need to get on with the case did play a role and I think I've indicated that previously, yes.

Q. And then the next point that I wanted you to consider is, in pressing on in that way: do you accept that what happened was, in wanting to get on and to give the surgery and the kidney graft its best chance of survival, you put Adam at risk?

A. Yes.

Q. Thank you. Then if we can go to the final paragraph in this statement:

"I recognise that the administration of excessive volumes of hypotonic fluids, such as Solution No. 18, can produce a movement of water into the cells of the body and, in particular, lead to cerebral oedema, known as dilutional hyponatraemia."

I want you, please, to focus on that word "can". Is it "can" or is --

MR UBEROI: I only rise -- from my recollection, the witness did speak to this this morning and answer it with clarity then. I leave it in my learned friend's hands.

MS ANYADIKE-DANES: I think he was asked the question as to whether he considered that Adam could and did develop dilutional hyponatraemia. This is a slightly different question.

THE CHAIRMAN: Sorry, what is this question?

MS ANYADIKE-DANES: This question is: do you recognise that the administration of excessive volumes of hypotonic fluids won't just "can" produce a movement of water into the cells of the body, but will?

A. Yes.

Q. Thank you. It's just a process of osmosis; it will do it.

A. Unequivocally, yes.

Q. Unequivocally, thank you. That was the point of the question.

Then if we move to page 4, which is witness statement 008/6, page 4. You then express:

"[Your] deep regret for the tragic death of Adam and [your] sorrow for his family and [you] assume responsibility for the calculations and administration of all the fluids that Adam was given during his renal transplant and accept responsibility for them being incorrect."

Isn't that right?

A. That's correct.

Q. Thank you. I'm sorry, Dr Taylor, that's taken rather longer than I had wished to do to go through your two statements. What I want to do now is I want to actually go back, as I do from time to time, to 1995 and work through your conduct in relation to Adam's transplant

surgery.

Firstly, I had mentioned the renal transplant protocol. That's the protocol that Dr Savage, as he then was, produced in 1990. Can we just pull that up? Witness statement 002/2, I think page 52. There we are. There it is.

Do you see that, Dr Taylor? When did you first see that renal transplant protocol? When did you first see it?

A. I don't recall seeing it.

Q. Do you not recall seeing it before Adam's transplant?

A. I don't recall seeing it before Adam's transplant.

Q. Did you know that there was one?

A. I can't remember if there was one.

Q. Okay. You've seen it since his transplant?

A. Yes.

Q. When did you see it after his transplant?

A. I can't recall.

Q. I'll just ask you another question to see if I can assist and, if not, we'll move on. Did you see it before the inquest?

A. In 1996?

Q. Yes.

A. I can't recall. I can't recall having made reference to it, which would confirm that I had seen it, so without

making reference to it, I can't speculate. So I have to say I can't recall seeing it before his inquest.

Q. Did you ask whether there was any guidance or procedure or practice prior to his surgery?

A. I can't recall if I asked to see it.

Q. Well, not necessarily to see this, but in your telephone conversations with Dr Savage, did you ask if there's anything that's going to guide what happens to him preoperatively on the evening of, for example, his surgery? Did you ask?

A. I didn't keep a record of the telephone call I received on the Sunday night, so I can't say if I asked, "Was there a protocol?".

Q. Okay. I'm going to work through a period literally prior to the surgery and then we'll move into the period of his actual surgery and the time in theatre and then afterwards, just to give you the direction of flow.

So can I ask you first about a pre-surgical visit and assessment. At some points, you've thought that maybe you did see Adam's mother and then, at other points, you thought perhaps you didn't see her.

A. Yes, I didn't record seeing Adam's mother and it is my usual practice to see the child and the parent prior to the operation. I do not recall that visit. I did not come in on the night of the 26th before the operation

because I believed, at that time, the plan was to come in fresh in the morning. I regret not coming in the night before to see Adam because it was a potential opportunity to gain information about his fluid status and his dialysis.

Q. Forgive me if I ask you a question that I've already asked you: is this your first paediatric renal transplant?

A. As a consultant?

Q. Yes.

A. I have said it is.

Q. And how many had you done not as a consultant?

A. I haven't a record of how many I did as a trainee anaesthetist.

Q. We'll check. Anyway, as you say, this is your first as a consultant.

A. Yes.

Q. And you get a phone call from Dr Savage in the evening. I appreciate that the decision is: let's all go in fresh first thing in the morning. If you're going to do that, how much time were you going to allow yourself for the purposes of going through his medical notes and records, having any further discussion that you might want to with Dr Savage and examining Adam?

A. I would have expected to give about an hour to assess

a patient before a transplant.

Q. Let's work that back. Leaving aside the possibility that the surgery may actually have started at 1.30 or thereabouts -- that is dispensed with and I'm going to come to that in a minute. But it appears that between you and Mr Keane, the decision is that perhaps the better thing to do would be to start it at 6.

If you're going to start the surgery at 6, what does that mean in terms of when you need to get to the hospital to do all the things that you want to do, look at the notes, speak to Adam's mother, examine Adam? What does that mean?

A. Well, it would mean I'd need to leave over an hour to be in the hospital before the operation was due to start.

Q. So are you saying that if the operation was due to start at 6 o'clock and you got into the hospital at 5, that would be sufficient time to look through his notes and examine Adam, speak to his mother and perhaps speak to Dr Savage if he's about? An hour would do it?

A. I think I said over an hour.

Q. Sorry, I didn't mean to misrepresent. I'm actually just trying to find out how long. It's for you to tell me. When do you think you would have been aiming to get there if the operation's going to start at 6?

A. Before 5.

Q. Before 5. In fact, if we go to your witness statement at 008/1, page 2, I think you may have actually addressed this, which I should have provided you with, I'm sorry. It's at (i). If we start from:

"I was on call ..."

Then you go through:

"I was informed that Adam retained his native kidneys."

That's after you've had your phone call from Dr Savage:

"I suggested coming in to assess him, but we concluded that relevant information could be given by phone and that I would be required to start the case at 6.00 next morning. This meant leaving home at 5.15 to prepare the patient, drugs and perform my pre-anaesthetic equipment checks."

So I'm just trying to understand what you mean by all that. If you're leaving your home at 5.15, when are you getting to the hospital?

A. About 5.25.

Q. And where in there are you looking at his medical notes and records in that list?

A. Yes, well, I can see what you're saying and it conflicts with my earlier statement. In fact, at some stage, his operation gets bumped back to 7.

Q. Yes.
A. I don't know why that is. I can't recall.
Q. Right.
A. But it may be as a result of the telephone call I received from Dr Montague. But there was a change of plan at some stage and I don't know why. This note conflicts with that, but the fact was that he didn't arrive in the operating theatre until nearly 7.
THE CHAIRMAN: I'm sorry, doctor, your paragraph 1 is quite explicit:

"I would be required to start the case at 6 o'clock the next morning. This meant leaving home at 5.15."

If you were stating at 6 o'clock, you left home at 5.15, you get there at about 5.25 and the operation's due to start at 6, according to that statement; isn't that right?
A. That is correct.
THE CHAIRMAN: Which gives you 35 minutes to go through the things that you spoke to Ms Anyadike-Danes a few moments ago about, rather than a bit over an hour.
A. Yes.
MS ANYADIKE-DANES: What I was going on to say is that in that list that you've got there, I don't see in that list, "looking through his medical notes and records". What I wondered if what you were suggesting is that the

information that you were going to get or were getting from Dr Savage over the phone was in some way a substitute for looking through his medical notes and records.

THE CHAIRMAN: Does he not say? In the second paragraph, second line:

"I knew I would have to make a more detailed examination of the medical records."

And a few lines down, doesn't he say that:

"At 5.45, I met with Adam and his mother and reviewed all available information."

MS ANYADIKE-DANES: Yes, I'm going to come to that. The problem is that there is an issue as to whether he actually did meet Adam's --

THE CHAIRMAN: I know there's an issue about meeting Adam's mother, but I thought your last question was based on there's no reference to him looking at the notes and records.

MS ANYADIKE-DANES: There's no record in the list. When he says, "This meant me leaving home at 5.15", when he says what he's going to allocate his time to, he says:

"To prepare the patient, drugs and perform my pre-anaesthetic equipment checks."

What I was putting to him is: when in that period of time from 5.15 to when he thought the operation was

going to start at 6 o'clock was he allocating time to look at the medical notes and records?

THE CHAIRMAN: I see.

MS ANYADIKE-DANES: Dr Taylor?

A. Yes, I don't know what I meant by that. That's ... I can't explain that time difference with my previous statement.

Q. But were you always going to have to look at his medical notes and records?

A. Yes.

Q. Yes. Am I understanding you to say that you would not have embarked on the surgery without looking at his medical notes and records?

A. Dr Savage --

Q. No, no, forget Dr Savage. From your point of view, would you have been prepared to embark on inducing Adam into anaesthesia for a transplant surgery without looking at his medical notes and records?

A. No.

Q. No. So how could you know that leaving your home at 5.15 for an operation that was due to start at 6 o'clock would leave you sufficient time to look at his medical notes and records as well as do all those other things in your list?

A. Well, it may not have left me sufficient time to do all

that I wanted to do, but the importance of reading the notes and making the checks would then have delayed the surgery.

Q. I'll come to that point in just a minute. Did you know at that stage how extensive Adam's medical notes and records were?

A. I had anaesthetised Adam before, so I would have had some idea that he had multiple admissions to hospital and, therefore, a large number of notes.

Q. Well, I'm just going to try and pull up the surgical schedule that we had -- that the legal team had provided so that we can see that. Sorry, if you give me just one moment. There's a summary of it, and the summary is 300-060-107. Perhaps we can pull that up. Thank you.

The second column from the far right-hand side is the anaesthetist column. There are two pages of this, but the only reference to you on the second page is in relation to the kidney transplant, so we'll stick with this page.

So we can see that you are his anaesthetist in the procedure on 20 December 1991 and then 25 February 1992. Does that accord with your recollections, that you anaesthetised him three times before?

A. I can't remember.

Q. Sorry, there's another one, I beg your pardon. There's

24 December 1991. So there's 20 December 1991, 24 December 1991, 25 February 1992. By the time you get to 1992, he's had quite a substantial amount of significant work done, if I can put it that way; is that right?

A. Yes.

Q. Right. I put it to you again. Had you any appreciation, in 1995, of the extent of Adam's medical notes and records when you got that phone call from Dr Savage to ask if you could be the anaesthetist for his transplant surgery?

A. I can't remember.

Q. We actually have his medical notes and records here.

THE CHAIRMAN: Ms Anyadike-Danes, I'm not sure you need to dwell on this point because what the doctor said a few minutes ago, when you asked him was he aware how extensive Adam's medical notes and records were, he said:

"I had anaesthetised Adam before, I would have had some idea that he had had multiple admissions and therefore a large number of notes".

There's no dispute. If you had anaesthetised him a number of occasions before and you remembered that and you remembered having treated Adam before and he was coming in for a renal transplant, it would inevitably

follow that he had a large number of notes and records, wouldn't it?

A. I believe so.

THE CHAIRMAN: Yes. Therefore when you were coming in that morning, leaving your home at 5.15, you would have known -- let's put it bluntly, if the operation started at 6, you wouldn't have time to prepare for it in the way that you would expect to be prepared for it?

A. That's correct.

THE CHAIRMAN: Thank you.

MS ANYADIKE-DANES: So then why were you leaving home at 5.15?

A. I can't remember. I have made a record of the time, so it appears it was 5.15 when I left home and approximately 5.25 when I arrived in, so I -- other than that, I can't remember.

Q. I think you've accepted that you didn't examine Adam; is that correct?

A. I have no recollection of examining Adam and I made no record, so ...

Q. Well, let's put it another way. If you had examined Adam, would you have made a note of your examination of him?

A. Yes.

Q. Right. And there is no note of your examination of him?

A. That's correct.
Q. If you were examining Adam, what would you be examining him for? What's the purpose of the anaesthetist's pre-surgical examination?
A. My usual practice is to see if the patient is well and awake and alert, to make sure the airway is patent, their breathing is adequate and they have an intact circulation, heart rate and blood pressure are stable. Those would be the main elements of the anaesthetic examination.
MR UBEROI: [Inaudible] change of questions, may I ask that 058-003-007 comes up in case it assists the witness?
MS ANYADIKE-DANES: Thank you, "Anaesthetic record".
Do you know when that was completed?
A. On 27 November 1995. But there's no time stamp on it, so I can't say when it was completed.
Q. Well, do you know when in relation to Adam coming into the operating theatre that was completed?
A. It would usually be completed prior to the patient arriving in the anaesthetic room.
Q. Yes, maybe you could help --
"Preoperative assessment, ASA classification."
And then a string of numbers, and then "3" is circled. What does that mean?
A. The ASA classification is the American Society of

Anesthesiologists -- and do you want me to describe the numbers?

Q. Yes.

A. Number 1 is a healthy patient with no illness or no systemic illness. Number 2 is a healthy patient with a systemic illness without any symptoms or signs, so somebody who is well perhaps with asthma. Number 3 is a patient with a systemic illness, but who's controlled and I classified that to be Adam. He had chronic renal failure, which is a systemic illness and it's being controlled by medication and dialysis in his case.

Q. Does that help you, looking at that form now, as to when you think -- firstly, who completed that form?

A. That's my writing.

Q. And you signed off on the anaesthetist's signature. So if it's your writing, maybe you can help us interpret it. What is written -- let's make sure we've got all the information in correctly. Significant history. Can you just read off what's on those two lines?

A. "H/O", which is "history of". And then there's an abbreviation, which is "PUJ", which I ... I can't remember what that was.

Q. Okay.

A. And there's an arrow pointing to "renal failure". And then underneath that it's "well recently". And then

it's "no URTIs", which is no upper respiratory tract infections. That would obviously make a patient less fit for an operation.

Q. "Previous anaesthetic."

A. "Multiple." And then there's "G tube". I presume that was the last one or recent one, which was a gastrostomy tube, I think an abbreviation for that.

Q. Then "polyuric", is that right?

A. Then there's a tick box for:

"Airways, normal. Loose teeth, no. ENT, normal. Respiratory, normal. CVS, normal. CNS, normal."

That's central nervous system. And then:

"Hepatic/renal, no. Polyuria."

Q. Then under the proposed management?

A. "IPPV", intermittent positive pressure ventilation, which meant I was going to put him on a ventilator.

Q. And below that?

A. Beside that, sorry, "epidural".

Q. Okay.

A. And below that, "Post op, PICU", paediatric intensive care unit.

Q. And I see there's nothing under "anticipated problems". Is that because you didn't anticipate any?

A. Possibly.

Q. Then if one goes down to "surgical speciality", is that

"gen" for general?
A. Yes.
Q. And under "patient's state on arrival", is that "crying"?
A. I believe so.
Q. And then your signature and the date.
A. Yes.
Q. Does that mean that this is filled in on the patient's arrival, you assess the patient and complete this? Or does that not mean that?
A. The pre-anaesthetic sheet is the front page of the anaesthetic record and that is usually filled in on the ward when the patient is seen prior to the operation.
MR UBEROI: If I might add, just in case you were to leave this document in the near future, a bit that wasn't mentioned. Before we go into the tick boxes, just to the left, I don't know if the witness could have his attention drawn to the "physical exam" phrase.
THE CHAIRMAN: That there was a physical exam, you mean?
MS ANYADIKE-DANES: Yes.
THE CHAIRMAN: In essence, what you're being asked -- I think you had previously said a few minutes ago that there was no note of you having examined Adam, therefore you didn't. And I think the point of this document being -- of you being taken through this document now

is: does this mean that contrary to what you thought a few minutes ago, does this document show that you did in fact examine Adam before the anaesthetic?

A. I can't say when this document was completed, so ...

MS ANYADIKE-DANES: It's a slightly different question actually, Dr Taylor. Does it mean that whenever you completed it, you had carried out a physical examination of Adam?

A. It would indicate that I had seen Adam's systems, yes.

Q. And can we just understand, for the purposes of completing this form and ticking that, what would that entail?

A. That would indicate that he was --

Q. No, no, what does the physical examination entail?

A. It would mean his airway was examined, his ear, nose and throat were examined, his respiratory, cardiovascular and CNS were examined.

Q. And is the position that you don't actually know now whether you did that on the ward or you did that in the operating theatre when he was brought in?

A. I have no time on this, so that's correct.

THE CHAIRMAN: But are you saying then that this shows -- I just want to make it clear what I'm supposed to understand from this. Do I understand from this that whenever the form was completed, you did actually

examine Adam before you put him under anaesthetic?
A. I can't tell by this sheet when that physical exam was completed. I can't remember. The usual practice is to do it before the patient goes to sleep.
MS ANYADIKE-DANES: Do you mean you might have done it after you had anaesthetised him?
A. As we go on, you will see or we'll find that Adam was upset on arriving in theatre, which may have -- would have made an examination very difficult. So it's possible that the examination was done after he went to sleep.
THE CHAIRMAN: If I take one example, would you put him to sleep if you didn't know whether he had an upper respiratory tract infection?
A. That would be gained in the history.
THE CHAIRMAN: From the ward or from --
A. From the ward, from the checklist.
THE CHAIRMAN: Thank you.
A. From the doctor's examination on the ward.
MS ANYADIKE-DANES: Sorry, let's just sort of roll back a little bit. What is the purpose of the physical examination?
A. The purpose of the physical examination is to ensure that the patient's systems are fit at the time of anaesthesia, prior to anaesthesia.

Q. Exactly. So is there very much point in anaesthetising a child and then conducting the physical examination in case it turns out that it's inappropriate to anaesthetise that child or to proceed with the surgical procedure?
A. I see what you're getting at. In some cases, it may not be possible to examine the patient before he goes to sleep because he's upset, in a young child, and it may be that we take the doctor who's examined the patient on the ward prior to his anaesthetic, the junior doctor or the consultant who's seen the patient on the ward and use their physical exam if it's been documented to assist us in examining the patient before they go to sleep.
Q. I understand. And is that what you did?
A. I can't remember. But it is unlikely that he would have been examined if he was crying. It's unlikely I would have got the detail of the examination that I required if he was being asleep, but I can't remember.
Q. I understand that. So if it's not happening then, it means that you are relying on the adequacy of the note that was made of the examination of Adam on 26 November; is that correct?
A. That would be correct.
Q. Thank you. I wonder if we can now pull up an extract

from Dr Haynes' report, 204-013-179? (Pause).

204-013-179? It's not showing. Okay. Sorry, I beg your pardon. I think it's actually Dr Coulthard's report. 200-013-179.

I think if we go to the first paragraph under paragraph 3 beginning, "I was first", right at the top under paragraph 3. Block that out in blue. Thank you:

"Here Dr Taylor states that although it is (and presumably was in 1995) his usual practice to see patients before their operation, he did not visit Adam prior to him arriving in the anaesthetic room for his transplant operation. He also states that he does not recall whether he discussed the risks of the anaesthetic with Adam's mother, since it would neither be appropriate nor possible to do this with her in a meaningful way while she was accompanying Adam into the anaesthetic room as he was about to be anaesthetised for major surgery. Dr Taylor's statement effectively excludes him having provided her with a fully informed or timely description of the risks."

MR UBEROI: Before we go any further, may I just lay down a marker as to my concerns about this particular approach? Dr Coulthard is not a paediatric anaesthetist. You have expert evidence from a paediatric anaesthetist. This point can now be put in

the context yesterday of Dr Savage's very fair acceptance of the limits of his expertise as a nephrologist and I would be far more comfortable on behalf of Dr Taylor if he was having put to him comments from Dr Haynes, who is the expert from his like expertise, and I'm very uncomfortable about Dr Coulthard's views on the adequacy or otherwise of his actions as an anaesthetist being put to Dr Taylor in this way.

MS ANYADIKE-DANES: Thank you. Let's go to reference 204-004-162. Maybe start at 161, sorry. Under paragraph 21:

"Dr Taylor's approach to and execution of the duties and responsibilities expected of a consultant paediatric anaesthetist while carrying out a paediatric renal transplant operation. Preoperative assessment: Dr Taylor did not visit Adam and his mother on the eve of surgery. Had he done so, he could at relative leisure: (a) have had an opportunity to examine the case notes in detail; (b) thus identify that inadequate sodium administration and/or water overload had resulted in hyponatraemia on previous occasions, including on one occasion in relation to an anaesthetic he himself had administered in December 1991; and (c), formulate a strategy for intravenous fluid therapy which

would have avoided this happening (if necessary, checking his thoughts with regard to fluid and electrolyte management with Dr Savage)."

Pausing there, do you accept that?

A. Yes, as I've said before it is my usual practice to visit a patient, a child patient, and his parent prior to anaesthetic the night before and preferably have a face-to-face meeting with the patient and the parent and, presumably, Dr Savage. I did not do that and the reason I did not do that is because it was felt by myself and others that we had to be fresh for his transplant procedure in the morning.

Q. I understand that.

A. I regret that. It was a mistake.

Q. I understand that also. The point that I'm putting to you is what Dr Haynes is saying is what you could have achieved with such a meeting, "had he done so", and then he cites at (a), (b), and (c), the benefits. And I just want to be sure that you're accepting --

A. Unequivocally, yes.

Q. If we move on, it says:

"The operation was scheduled to start early in the morning and some discussions were held with Dr Savage on the eve of surgery. Had Dr Taylor visited Adam and his mother on the eve of surgery and even briefly discussed

Adam's past medical history, I think that he would have realised how susceptible Adam was to either water overload or inadequate sodium replacement and formulated his fluid replacement plan more appropriately."

Do you accept that?

A. Yes.

Q. Thank you. Then I think if we can move to the next page, 204-004-162. I think it's the final paragraph, the second paragraph:

"Although formal written consent for an anaesthetic and all that is entailed is still not universal throughout the UK, a preoperative visit by the anaesthetist is normal practice. This ensures that the parents and child (if old enough to understand) are cognizant of the various components of an anaesthetic, including central venous line insertion, epidural insertion, and that they agree to blood transfusion if necessary. It is disappointing that Dr Taylor did not visit on the eve of surgery. Had he done so, examination of Adam may have made him realise that there might be difficulty with central venous line insertion."

Pausing there, you were going to insert a central venous line, weren't you, Dr Taylor? Not you personally, but there was going to be a central venous line for the purposes of the operation?

A. Yes, that's correct.
Q. And there was going to be an epidural?
A. Yes.
Q. Do you accept therefore here what Dr Haynes is saying, that this would also have been a benefit of an examination or a meeting between you and Adam's mother and Adam?
A. Yes, he describes it as normal practice and that is my normal practice as well.
Q. It's not just the normal practice point I'm trying to -- it's the benefits of doing it.
A. Correct. Yes.
Q. Thank you. Can we come back to the full page? Thank you. Can we move on to the relationship of medical records since we're here. If you can highlight that final paragraph:

"Adam's medical records would no doubt have been very bulky, extending over more than one volume, and it would have taken considerable time to sift through these to find the salient pieces of information. It is difficult sometimes to distil information together to provide a concise summary. When assessing a complex patient for the first time, the following pieces of information are among the most useful."

Can we go to the next page?

THE CHAIRMAN: Without reading out all the bullet points, do you see the point being made, doctor?
A. Yes.
THE CHAIRMAN: And you have seen this report from Dr Haynes before?
A. Yes.
THE CHAIRMAN: Do you accept the point he's making?
A. I do accept the points he's making.
MS ANYADIKE-DANES: As it turns out Adam's medical notes and records were very bulky; isn't that right? They've been in the chamber, so people will have had an opportunity to see them. They are extensive; isn't that right?
A. Yes.
Q. And so to sift through those and find out whatever it was you wanted to find out in order to plan his anaesthesia his fluid management, that was going to take some time; isn't that right?
MR UBEROI: If I may simply observe: on my understanding of the evidence, there's certainly a lack of clarity as to which medical records were in fact available on the morning. I just wonder if it would assist if the witness is taken through it in that sequence: does he, in fact, remember what he was confronted with when he arrived? And if so, can he help further with what may have been there or not?

MS ANYADIKE-DANES: Absolutely right. I think that would be a helpful way. I wonder if we can just show them.

There we are. I'm informed by the trust that those are Adam's medical notes and records. When you got to the hospital, what did you ask to see by way of his medical notes and records?

A. I can't remember.

Q. Okay. What would you have wanted to see?

A. I would have wanted to see his complete notes, but the most relevant ones would be his most recent notes. Sometimes that's the only notes that are available. I cannot recall if all Adam's notes were there. But his recent notes were because there was writing in them from that admission.

Q. Let me help you, as obviously it's a long time ago, and you have referred to some of these matters in your statements. Can we go to witness statement 008/2, page 4. At (f):

"I can recall going through his notes, reading his current admission including blood investigations, previous anaesthetic records and drug kardex and they were located on the ward as I remember."

Can you assist with specifically what you were looking for in his blood investigations and his previous anaesthetic records?

A. The anaesthetic records were quite easy to find in the medical notes in the Children's Hospital. They have a red tag on the bottom right-hand corner. So the sifting of the notes is very rapid to find the anaesthetic records. That would be my first or one of my first things to look for. So whatever anaesthetic records would have been available in the notes that were available, I would scan those first.

Q. Scan them all?

A. I would scan whatever was available in terms of the anaesthetic records, the red tags. And I would look to see if there was anything untoward in previous anaesthetics. That would give me probably the most important information, relevant information, for my anaesthetic management.

Q. And what about the blood investigations that you say you recall looking at? Where would you have been looking in his medical notes and records for those?

A. The recent blood investigations may well have been written in or sitting on a Post-it on the ward after a phone call. So they would very often be attached to the records. But the printout from the lab on a recent blood sample would not have been filed in the notes.

Q. What I wanted to ask you is: if that's all you were looking for, the recent laboratory results of his blood

investigations -- or were you going further back or would you have been wanting to go further back than recent, if I can put it that way?

A. Of course. The recent ones are the ones that are most relevant, but in a patient like Adam there was a need to reflect and look at, examine, his older blood tests to see if there were problems with his blood, with his electrolytes or with his haemoglobin.

Q. And do you know how far back you went?

A. I have no record of how far back I went.

Q. Were you trying to look at all of them?

A. I can't remember.

Q. Why were you looking at more than just the recent ones? What was the purpose?

A. To investigate if there was a pattern or if there was a problem with his previous blood tests. They're all filed together, so it's a matter of scanning the back pages of the medical records where the various electrolytes and blood tests are gathered, clotting screens, that sort of thing.

Q. We have actually looked at that, and for the purposes of the inquiry we have tried to prepare -- well, we have succeeded in preparing a graph of those. I'm just going to try and pull it up so that we can have some appreciation of how many of those records you might have

been looking at. Can we pull up 300-059-079?

That's the graph that was prepared of all his results. Each and every one of those blue dots represents a result. When you were saying you were flicking through the laboratory results, was it your intention to have flicked through them all to get an appreciation, I think you said, of whether there was a pattern or a problem?

A. I cannot remember if I looked at them all or the ones that were available. I believe or I may be wrong, but I have a vague memory of a summary sheet of his blood investigations near the front of his recent medical records.

Q. Perhaps --

A. That is very often present in a patient who's been in and out of hospital with such a long pattern of records.

Q. Let's pull that up. That might be 058-011-033. Is that what you might have been looking at?

A. Well, that one says "1992/1993".

Q. And I think unfortunately it's ... Can we maybe go to the next page?

A. They would be less relevant.

MR UBEROI: Perhaps if there's a page reference to be found -- I do note the witness has been going for an hour and a quarter now and I would ask for a break

at the next possible moment.

THE CHAIRMAN: We'll stop shortly, doctor.

MS ANYADIKE-DANES: The next page, that seems to be 1995. And unfortunately, as ill luck would have it, the smudging happens to be just around the sodium level.

THE CHAIRMAN: But is that the sort of document that you're talking about, doctor?

A. Yes, I think that I would generally find a summary sheet like that more useful than going through a set of printed blood results.

MS ANYADIKE-DANES: Just so that we're clear: are you indicating that you would have gone through those summary sheets, which start in 1991, and come up to 1995?

A. If they were available, yes.

Q. Just to see if we can close off this issue: does that mean if all of his medical notes and records are not on the ward, it could be possible for some of the earlier investigation summary sheets not to be with his medical notes and records, the ones on the ward?

A. Sorry?

Q. Let me put that a different way. We've just seen that this summary sheet goes from 1991 up to 1995 and we've also seen that his medical notes and records were rather extensive. So if they are kept on the ward, only the

most recent ones, is it therefore possible that you only had the investigation summary sheet dealing with the most recent records? You may not know. I'm just asking.

THE CHAIRMAN: I'm not sure --

A. I think that's a logical conclusion, yes.

THE CHAIRMAN: I think, doctor, you said you had a vague memory of a summary sheet of his blood investigations. The page on screen and the page before that are the summary sheet, aren't they?

A. Yes.

THE CHAIRMAN: So accepting there's some degree of uncertainty or cloudiness about it, you accept you have a vague memory of looking at this?

A. I think so, yes.

MS ANYADIKE-DANES: Sir, the point I'm trying to ask him is: there are two summary sheets and what I'm trying to see is whether they keep all the summary sheets together or whether the most recent summary sheet would be there with the notes on the ward and the summary sheets relating to his earlier medical notes and records kept with those earlier medical notes and records. That's what I was seeking to put to you.

A. I wouldn't ...

MR UBEROI: Sorry, I think we are in danger of getting very

confused here and it was just to remind everybody that the witness, in attempting to assist, originally prefaced all of his answers by suggesting he didn't remember clearly.

THE CHAIRMAN: He's got a vague memory -- which I accept -- from 16 or 17 years ago.

Could you talk to Ms Anyadike-Danes and, for the purposes, speak to your client, to see how much longer we can continue after 4 o'clock? We won't stop before 4.30. If possible, I'd like to go a little longer, but maybe the two of you could liaise on that.

MR UBEROI: Of course.

THE CHAIRMAN: Thank you.

(3.44 pm)

(A short break)

(4.00 pm)

(Delay in proceedings)

(4.10 pm)

MR UBEROI: Sir, I might just update you on the conversation that I was grateful to have with my learned friend. She's very understandably indicated that there's no prospect of her finishing today. And in light of that, if I may say, I would be very uncomfortable with the prospect of sitting after 4.30. I don't think anything is to be achieved by it and while, normally, I can fully

understand the pressure of a timetable, I don't think this is the witness with which we should sit late.

THE CHAIRMAN: No, thank you, Mr Uberoi. I had received a message to say -- not only from your client's perspective, but also, I think, Mr McBrien, from your client's perspective -- that it's been a very difficult day for a lot of people and I'm not going to push sitting late, doctor. So we'll finish today at 4.30 and resume tomorrow morning at 10 o'clock.

MS ANYADIKE-DANES: Dr Taylor, we've been going through what you -- I think we've been going through what you might have deduced or learned, put it that way, from the medical notes and records that would have been available to you, and I think you've been explaining the sort of things that you would be looking for. I think you said one of the first things you'd be looking for is the most recent medical notes and records and then you'd be looking for his blood investigations and so forth. And if we deal with the most recent, does that mean you'll be looking for the medical notes and records that really relate to his admission?

A. Yes.

Q. Part of that might be because -- I think you had earlier said that if you hadn't, and you can't now recall whether you did or didn't, carried out a physical

examination of him because he was upset, then the medical notes and records would permit you to have some of the information that you might have had if you had carried out a physical examination; is that an accurate summary of it?

A. Yes.

Q. The medical notes and records that would be available to you: I just want to see if you can say whether this was the sort of thing you'd have been looking at. 058-035-131. That's from 11.30. It's not necessarily in the right order, but in any event, that's a record that would have been available to you; is that correct?

A. Yes, I think it's his clocking-in sheet. His admission sheet, yes.

Q. And then if we move on to 144, 058-035-144. Sorry, it is slightly out of order. There you can see 26 November, 9.30. This I think is by Dr Cartmill, the SHO. And then you see him being in at 9.30, "possible renal transplant", and then you see the notes that she's made.

And then you see he's to have IV fluids at 75 ml an hour. Then you can see, on 26 November, at 11, you can see some results there. There's a sodium result in particular, which I think some have interpreted as 139, others have interpreted it as 134. Dr O'Neill, whose

note it is, says it was 139 and I think Dr O'Connor, who had had interpreted it as 134, has accepted that it was 139. Can you recall at this stage, what you made of that particular sodium result? Sorry, let me start again. Do you recall seeing this particular note?

A. I can't remember, but it would have been available to me when I arrived in the hospital.

Q. And can you recall -- you've probably dealt with it in a statement -- whether you interpreted that as 134 or 139?

A. 139.

Q. Yes. And then if we go back to -- I think this is the better order -- 131. There you are. You can see the rest of the note taken at 11.30.

Then if we pull up, I think, 057-019-028. It's a very bad copy, but it's a request for a chest X-ray. Are you looking at that sort of thing in your checking of the medical notes and records? Are you looking to see whether he's had a chest X-ray?

A. Yes, but that would be the request which wouldn't necessarily be kept in the notes.

Q. Exactly, but that wasn't quite the question I was asking you. Are you looking to see if he's had a chest X-ray?

A. Yes.

Q. And why would you be looking to see that?

A. To see if he's got any breathing or lung issues.
Q. And do you recall if you saw a chest X-ray?
A. I don't.
Q. And if you hadn't seen any reference to a chest X-ray, would it be your practice to ask if there had been one?
A. Um ... No. I don't think I would insist on a routine chest X-ray in an otherwise normal child, bearing in mind the radiation before a routine anaesthetic.
I would want to know if there's a reason for doing it.
Q. No, sorry, that wasn't quite the question I asked you. If you didn't see one, would you ask if there had been one?
A. Not necessarily for a fit child.
Q. Then just to go through the list of things, I think, that Dr Haynes has mentioned that you might be looking for:
"His normal current fluid balance and electrolyte requirements."
In fact, let's pull that up at 204-004-163.
It starts at the "in summary". The second paragraph:
"In summary, I would expect the anaesthetist to have sifted through Adam's notes to gain an understanding of the pathology involved and to identify particular problems. He/she should have introduced himself to the

patient and parents and also examined the patient as required. I would have expected any trainee working with me to have also done this and to have discussed his findings with me."

Then it says:

"Preoperative assessment is an integral part of the anaesthetist's duties. If not performed adequately, mistakes will inevitably be made."

Do you accept that? This is Dr Haynes.

A. Yes.

Q. Thank you. Can we pull up the full page? Okay. Then we'll see the list of things that Dr Haynes thinks that you should have gone on to ascertain. If we start at -- I think it's (iii):

"I would have expected Dr Taylor to have ascertained: the nature of Adam's underlying renal pathology."

Then he goes through what that would involve so far as he's concerned:

"Noting his current normal fluid balance and electrolyte requirements, his intake, his normal insensible fluid losses, the calculation of them, and noting his volume loss during peritoneal dialysis and therefore his average urine production, and noting that Adam required sodium supplements such as sodium

bicarbonate to maintain his normal sodium levels and that he could not regulate urinary sodium losses and to have realised that sodium had to be given as a constituent of all fluids administered and that repeated tests on Adam's blood were required to ensure that the sodium concentration remained within acceptable limits."

Then the detail of the "post-operative course following major surgery", especially:

"Noting the period when he was seriously ill in December 1991 to January 1992. And that he had had several central venous lines inserted and to have ascertained the details of his normal peritoneal dialysis regimen."

I'm not sure if it goes over the page, I think it does.

Right at the top of the page:

"To have read medical correspondence following recent nephrology outpatient visits. To have noted any difficulties encountered during previous anaesthetics. To have noted any other features regarding Adam's health in general."

Would you accept that that was the sort of thing you should have been going to his notes to ascertain?

A. Yes. That would be the usual preoperative check.

Q. Yes. And if you've got to do all those sort of things, do you think you did all those sort of things on 27 November 1995?
A. I can't remember if I did all those sorts of things.
Q. But you accept that's what you should have done?
A. I accept that's what would have been necessary under normal circumstances. I think it was slightly less than ideal circumstances, judging by the time of the morning and the urgency, let's say, of the procedure progressing.
Q. When did you first know what the cold ischaemic time was?
A. I can't remember. It may have been during the phone call, but I can't remember the phone call. It's 17 years ago.
Q. Right. But just so that we're clear, are you saying that the urgency of the cold ischaemic time of that donor kidney meant that you may not have done all those things that you accept were appropriate things to have done pre-anaesthesia?
MR UBEROI: I'm not quite sure where that comes from. We've run through the checklist of what Dr Haynes --
MS ANYADIKE-DANES: He said "under normal circumstances" and then he talked about the --
THE CHAIRMAN: "Slightly less than ideal circumstances."

MS ANYADIKE-DANES: Yes, that's what I'm trying to tease out. What made these slightly less than ideal circumstances then?

A. I said because of the time of the morning.

THE CHAIRMAN: And you said: judging by the time of the morning and the urgency, let's say, of the procedure progressing.

A. Yes.

MS ANYADIKE-DANES: Right. What creates the urgency for the procedure?

A. Well, you've mentioned the cold ischaemic time.

Q. I know, I don't want to make a suggestion if that's not appropriate. It's your evidence.

A. I think it is the desire to get the kidney into the patient before it becomes too late for the kidney to have a good chance of working.

Q. From your point of view, what was too late?

A. It's not my expertise to assess the length of the cold ischaemic time, but the impact of my procedures on the patient's anaesthetic and preparation for surgery will have an impact on the overall length of time that the kidney is in the ice and preservative.

Q. But did anybody tell you that: we must be moving quickly with this surgery because, for example, of the cold ischaemic time?

A. I can't remember if anybody told me that, but I can imagine -- and with kidney transplants I've done since Adam and before Adam -- that there is a desire to not waste time or not unnecessarily impede the patient's progress to the anaesthetic and surgery --

Q. And then the question --

A. -- bearing in mind that safety of the patient is paramount.

Q. Well, then that was the question I was going to put to you, which is: where we started from was the urgency to proceed with the surgery in view of the cold ischaemic time of that donor kidney; did that mean that you didn't necessarily carry out all the investigations of the medical notes and records in terms of those bullet points that you would otherwise have done?

A. I can't remember exactly what I did to assess Adam and prepare him for surgery. I would have ensured that the safety of his anaesthesia -- or at least the commencement of anaesthesia -- was not compromised by a rush to theatre. What I tried to say and indicate was that there should be no impediment or time wasting, which can happen prior -- that would delay the surgery. I'm not trying to imply that corners were cut to try and rush a patient to theatre. That is not what I am trying to express, if you understand.

Q. I do understand. But there are two things here: one is to have sufficient information to anaesthetise him safely; the other is to have sufficient information to administer his fluids safely; is that not right?
A. Yes.
Q. Yes. And what I am trying to find out is -- and if you don't remember, then simply say you don't remember -- if you'd ascertained all this information that Dr Haynes has set out in his report and which you accept is appropriate, whether you'd actually had the opportunity to do that for Adam prior to the commencement of his anaesthesia. That's what I'm trying to ascertain.
A. Well, I can't remember.
Q. You can't remember. Can you remember when you spoke to Dr Savage?
A. You mean the telephone call?
Q. Yes.
A. I didn't keep a record of the telephone call. I have indicated it was around about 11 pm.
Q. Why didn't you keep a record of the telephone call?
A. Because I was at home.
Q. Yes. Did you keep a record on something else which you didn't retain?
A. No.
Q. No? But Dr Savage was giving you, I think we understood

1 when we looked at the papers earlier, relevant
2 information about Adam. So why wouldn't you have kept
3 a note of that or a record of it?
4 A. I didn't keep a record of the telephone call.
5 Q. Would you now in those circumstances?
6 A. Yes, if I felt the information was as important, as it
7 was given for Adam, I think I would, yes.
8 Q. Does that mean you didn't appreciate that the
9 information that Dr Savage was giving you about
10 a prospective paediatric transplant patient was
11 important or significant?
12 A. I think what I'm trying to say is when I was given the
13 information at 11 pm the night before an operation, my
14 memory would have retained it long enough to be present
15 at 6 am the next morning. I think what I'm trying to
16 say is: I don't keep a record for what might be asked of
17 me a number of years later about the telephone call. So
18 I don't think my memory is so poor that I can't remember
19 important details by another doctor that would be
20 relevant a few hours later, if that clarifies the point.
21 Q. When did you formulate your fluid management plan for
22 Adam?
23 A. I can't remember.
24 Q. I think we can see it. That's in your first inquiry
25 witness statement. 008/1, page 4. If you look at the

top under "in summary", those were your calculations, but is that actually your plan? Your plan is to:

"Replace fluid deficit, mainly dilute urine, two hours. Provide fluid maintenance requirements each hour in theatre. Replace any blood loss by monitoring swabs and suction and so forth, replace blood. Further fluid management will depend on what the results were of the blood pressure, heart rate, CVP and organ perfusion, and the need to ensure that Adam's blood volume was certainly not deficient, but careful monitoring was actually increased in order to adequately perfuse the new, adult-sized donor kidney." Was that your plan going into the surgery?

A. Yes. It appears so.

MR UBEROI: Perhaps at that point, sir, it is now 4.30 and it's an appropriate moment.

MS ANYADIKE-DANES: It is.

THE CHAIRMAN: Thank you, doctor. Tomorrow morning at 10 o'clock. Thank you.

MS ANYADIKE-DANES: Mr Chairman, I think we've already had them -- we certainly had them today -- all the investigation summary sheets, which are clearer than they appear in the notes and maybe we will find a way of substituting them so that people can properly consult them. Thank you.

MR FORTUNE: Sir, before you rise, can I raise a matter of housekeeping? Can I ask you what time you propose to sit until tomorrow afternoon? It affects those of us who have flights.

THE CHAIRMAN: I'm delighted to see English visitors, but we will stop at 4.00 tomorrow.

MR FORTUNE: Thank you, sir.

(4.30 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X